

95 14501

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Harry Joseph Kelly				2. DATE OF DEATH MONTH April 30, 1995 DAY YEAR				3. TIME OF DEATH 10:46 a.m.			
4. SOCIAL SECURITY NUMBER 579-34-6271				5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 30, 1917		8. BIRTHPLACE (State or Foreign Country) Pennsylvania	
9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Frederick			9c. COUNTY OF DEATH Frederick		
RESIDENCE OF DECEDENT											
10a. STATE Maryland			10b. COUNTY Frederick			10c. CITY, TOWN OR LOCATION Adamstown			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 5528 Mountville Road						10f. ZIP CODE 21710			10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher				16b. KIND OF BUSINESS/INDUSTRY Public School System			
17. FATHER'S NAME (First, Middle, Last) William Francis Kelly						18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Convery					
19a. INFORMANT'S NAME (Type/Print) Mrs. Teresita E. Kelly						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5528 Mountville Rd., Adamstown, Md. 21710					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Joseph's Cemetery May 3, 1995				20c. LOCATION — City or Town, State Buckeystown, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard C. Bayford</i> M00021						22. NAME AND ADDRESS OF FACILITY Keeney and Basford Funeral Home 106 East Church St., Frederick, Md. 21701					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): b. Hypertension DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. P. Henry MD</i>						29c. LICENSE NUMBER D35553			29d. DATE SIGNED (Month, Day, Year) 5/1/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. P. Henry MD 610 9th Ave. Brunswick, MD 21716											
31. DATE FILED (Month, Day, Year) MAY 03 1995				32. REGISTRAR'S SIGNATURE <i>J. P. Henry</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14502

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CATHERINE IRENE KIENLE</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>28</b> YEAR <b>95</b>		3. TIME OF DEATH <b>4 A M</b>	
4. SOCIAL SECURITY NUMBER <b>577-01-3132</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>90</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 7, 1904</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Meridian Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>		9c. COUNTY OF DEATH <b>Frederick</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Kensington</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>10400 Connecticut Ave. Ste. 302</b>			
10f. ZIP CODE <b>20895</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Supervisor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Phone Company</b>	
17. FATHER'S NAME (First, Middle, Last) <b>James E. Lindsay</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Edna Mae Pittinger</b>			
19a. INFORMANT'S NAME (Type/Print) <b>J. William Keith</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8280 Greensboro Dr. Suite 540, McLean, VA 22102</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gates of Heaven Cemetery 5/2</b>		20c. LOCATION — City or Town, State <b>Silver Spring, MD</b>		22. NAME AND ADDRESS OF FACILITY <b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET THURMONT, MD 21788</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert E. Dailey</i>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Urinary Tract Infection</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Casper E. Cline III MD</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>4/28/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Casper E. Cline III MD 300 West Ninth Street Frederick, MD 21701</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 01 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14503

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Richard KRETLOW				2. DATE OF DEATH MONTH DAY YEAR April 30, 1995		3. TIME OF DEATH 6:04A M	
4. SOCIAL SECURITY NUMBER 218-03-3073		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 12, 1921	
9a. FACILITY NAME (If not institution, give street and number) Perry Point V.A.M.C.				9b. CITY, TOWN OR LOCATION OF DEATH Perry Point		9c. COUNTY OF DEATH Cecil	
10a. STATE Maryland				10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Aberdeen	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 336 Mount Royal Avenue				10f. ZIP CODE 21001		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman		16b. KIND OF BUSINESS/INDUSTRY Heavy Equipment	
17. FATHER'S NAME (First, Middle, Last) Henry Kretlow				18. MOTHER'S NAME (First, Middle, Maiden Surname) Erna Gewissen			
19a. INFORMANT'S NAME (Type/Print) Norma Kretlow				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 336 Mount Royal Ave., Aberdeen, Maryland 21001			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Baker Cemetery		20c. LOCATION — City or Town, State 5/4 Aberdeen, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gary R. DiSavanni				22. NAME AND ADDRESS OF FACILITY Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Asystole DUE TO (OR AS A CONSEQUENCE OF): b. Hypertension DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Manuel V Ramos, M.D.				29c. LICENSE NUMBER D38950		29d. DATE SIGNED (Month, Day, Year) 4-30-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MANUEL RAMOS, M.D. VAMC, PERRY POINT, PERRY POINT, MD 21902							
31. DATE FILED (Month, Day, Year) MAY 01 1995				32. REGISTRAR'S SIGNATURE John Anderson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

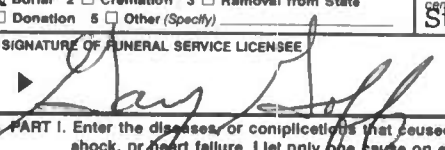
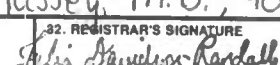
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14504

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Kenneth (NMN) Keen, Jr.</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>28</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>2:07 P M</b>	
4. SOCIAL SECURITY NUMBER <b>139-26-9038</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Apr 11, 1933</b>	
8. BIRTHPLACE (State or Foreign Country) <b>N.J.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1005 Windjammer Ct.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Churchton</b>	
9c. COUNTY OF DEATH <b>Anne Arundel</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>	
10c. CITY, TOWN OR LOCATION <b>Churchton</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1005 Windjammer Ct.</b>	
10f. ZIP CODE <b>20733</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1955-1958</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Real Estate Sales</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Real Estate</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Kenneth Keen, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mildred Mills</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Barbara A. Keen</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1005 Windjammer Ct. Churchton, MD 20733</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St James Parish Cem. 5-2-95</b>		20c. LOCATION — City or Town, State <b>Lothian, MD 20733</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Rausch Funeral Home, PA Owings, MD 20736</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Metastatic colorectal cancer</b> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>2 yrs</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Ann C. Massey, M.D.</b>				29c. LICENSE NUMBER <b>D44465</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/1/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ann C. Massey, M.D., 900 Bestgate Rd, Suite 300, Annapolis, MD 21401</b>							
31. DATE FILED (Month, Day, Year) <b>MAY - 3 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15+1



95 14505

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Eugene T. LaRue				2. DATE OF DEATH MONTH DAY YEAR April 21 1995		3. TIME OF DEATH 5:50 A M	
4. SOCIAL SECURITY NUMBER 560-74-0654		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 45 YRS.	7. DATE OF BIRTH (Month, Day, Year) Jan. 11, 1950		8. BIRTHPLACE (State or Foreign Country) California	
9a. FACILITY NAME (If not institution, give street and number) 1930 Flowering Tree Terrace				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1930 Flowering Tree Terrace				10f. ZIP CODE 20902		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES No		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16. KIND OF BUSINESS/INDUSTRY DC Public Schools			
17. FATHER'S NAME (First, Middle, Last) John T. LaRue				18. MOTHER'S NAME (First, Middle, Maiden Surname) Beatrice Tidwell			
19a. INFORMANT'S NAME (Type/Print) Darkeycio LaRue				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1930 Flowering Tree Terrace Silver Spring, Md 20902			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lincoln Park Memorial 4/28		20c. LOCATION — City or Town, State Compton, California			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lynne L McGuire</i>				22. NAME AND ADDRESS OF FACILITY McGuire Funeral Service 7400 Georgia Ave., N.W. Washington, D.C. 20012			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		s. Renal Failure DUE TO (OR AS A CONSEQUENCE OF): b. Acquired Immunodeficiency Syndrome DUE TO (OR AS A CONSEQUENCE OF): c. HIV Infection DUE TO (OR AS A CONSEQUENCE OF): d.					
Approximate Interval Between Onset and Death 3 months							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Kaposi's Sarcoma Hypertension DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard H. Parker MD</i>				29c. LICENSE NUMBER 3526		29d. DATE SIGNED (Month, Day, Year) 4-24-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard H. Parker M.D. 1160 Varunum St. NE. Wash. DC 20017							
31. DATE FILED (Month, Day, Year) APR 25 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 14506

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Joseph Wayne Ludwick				2. DATE OF DEATH MONTH DAY YEAR April 23 1995		3. TIME OF DEATH 5:30 P M	
4. SOCIAL SECURITY NUMBER 282-03-8042		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 94 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 28, 1900	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) 9039 Sligo Creek Parkway, Apt. 1212		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 9039 Sligo Creek Parkway, Apt. 1212	
10f. ZIP CODE 20901				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (6-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Credit Manager		16b. KIND OF BUSINESS/INDUSTRY Photographic	
17. FATHER'S NAME (First, Middle, Last) Anthony Wayne Ludwick				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nancy Elliot Brown			
19a. INFORMANT'S NAME (Type/Print) James Ludwick				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 20901 9039 Sligo Creek Parkway, Apt. 1212, Silver Spring,			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Crematory 4/25		20c. LOCATION — City or Town, State Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Staphylococcal Pneumonia</u>							
b. <u>Chronic obstructive Pulmonary Disease</u>							
c. <u></u>							
d. <u></u>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 135162		29d. DATE SIGNED (Month, Day, Year) 4/24/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL SCHINDLER MD 1106 SPRING STREET SILVER SPRING MD 20910							
31. DATE FILED (Month, Day, Year) APR 26 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 14507

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>IRENE LAMPL</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>22</b> , YEAR <b>1995</b>		3. TIME OF DEATH <b>9:50 P. M.</b>	
4. SOCIAL SECURITY NUMBER <b>197-36-9286</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>91</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>DEC. 25, 1903</b>	
8. BIRTHPLACE (State or Foreign Country) <b>LITHUANIA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>10609 GAINESBOROUGH ROAD</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>POTOMAC</b>	
9c. COUNTY OF DEATH <b>MONTGOMERY</b>				10a. STATE <b>FLORIDA</b>		10b. COUNTY <b>DADE</b>	
10c. CITY, TOWN OR LOCATION <b>NORTH MIAMI BEACH</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>19380 COLLINS AVENUE</b>	
10f. ZIP CODE <b>33160</b>				10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES: <b>X</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>HOUSEWIFE</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>OWN HOME</b>	
17. FATHER'S NAME (First, Middle, Last) <b>SOLOMON BERKOWITZ</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>RACHEL "UNOBTAINABLE"</b>			
19a. INFORMANT'S NAME (Type/Print) <b>SANFORD LAMPL</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>209 WOODBRIDGE WAY, SIMSONVILLE, SC 29681</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) <b>LAKEVIEW MEMORIAL PARK 4/25</b>		20c. LOCATION — City or Town, State <b>MIAMI, FLORIDA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Congestive Heart Failure</b>							
DUE TO (OR AS A CONSEQUENCE OF): <b>b. Pneumonic Heart Disease</b>							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kathy L. Lampl M.D.</i>				29c. LICENSE NUMBER <b>028038</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/22/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>KATHY L. LAMPL, M.D. 9711 MEDICAL CENTER DRIVE ROCKVILLE MD 20850</b>							
31. DATE FILED (Month, Day, Year) <b>APR 26 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 14508

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOEL LEVY</b>				2. DATE OF DEATH MONTH <b>04</b> DAY <b>24</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>01 55P</b> M	
4. SOCIAL SECURITY NUMBER <b>065-28-6591</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>59</b> YRS.		7. DATE OF BIRTH MONTH <b>04</b> DAY <b>13</b> YEAR <b>1935</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>HEBREW HOME OF GREATER WASHINGTON</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ROCKVILLE</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>ROCKVILLE</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>6121 MONTROSE ROAD</b>			
10f. ZIP CODE <b>20852</b>				10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>5+</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ENGINEER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>FEDERAL GOVERNMENT</b>			
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM LEVY</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ESTHER YOSKOWITZ</b>			
19a. INFORMANT'S NAME (Type/Print) <b>KIM LEVY (DAUGHTER)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7922 CORIANDER DRIVE-GAITHERSBURG, MARYLAND 20879</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. COMFORT CREMATORY 4/27</b>		20c. LOCATION — City or Town, State <b>ALEXANDRIA, VIRGINIA</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert L. Johnson</i>				22. NAME AND ADDRESS OF FACILITY <b>DANZANSKY-GOLDBERG MEMORIAL CHAPLES, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD. 20852</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. PRIMARY SPLENIC LYMPHOMA</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>6 months</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>D.D. Patel, M.D.</i> Attending Physician				29c. LICENSE NUMBER <b>718084</b>		29d. DATE SIGNED (Month, Day, Year) <b>04/25/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>D.D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852</b>							
31. DATE FILED (Month, Day, Year) <b>APR 26 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14509

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lena Victoria Lewis				2. DATE OF DEATH MONTH DAY YEAR April 25 1995		3. TIME OF DEATH 10:05 P M	
4. SOCIAL SECURITY NUMBER 579-40-8771		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 8, 1904	
9a. FACILITY NAME (If not institution, give street and number) Medlantic Manor Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 2601 Bel Pre Road				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY Association			
17. FATHER'S NAME (First, Middle, Last) Michele Morfesi				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annunziata Gravalles			
19a. INFORMANT'S NAME (Type/Print) Jean L. McCandlish				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Canborne Way, Madison, Conn. 06443			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 4/27/95		20c. LOCATION — City or Town, State Alexandria, Va.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Timothy J. Campbell</i>				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Sil. Spr. MD 20901			
23. PART I. Enter the diseases, for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pancreatic Cancer DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 4 mos.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Benjamin Avrunin, M.D.</i>				29c. LICENSE NUMBER D 08381		29d. DATE SIGNED (Month, Day, Year) April 26, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Benjamin Avrunin, M.D. 18111 Prince Phillip Dr. #T-14, Olney, MD 20832-1513							
31. DATE FILED (Month, Day, Year) APR 28 1995				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14510

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Marvin Eavenson Lescure, JR</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>30</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>4:58pm</b> M	
4. SOCIAL SECURITY NUMBER <b>137-18-2544</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 11, 1912</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Delaware</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Harford Memorial Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Havre de Grace</b>	
9c. COUNTY OF DEATH <b>Harford</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>	
10c. CITY, TOWN OR LOCATION <b>Aberdeen</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>29 Howard Street</b>	
10f. ZIP CODE <b>21001</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Safety Supervisor</b>				16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Marvin E. Lescure, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Florence Shertle</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Linda Walker</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>29 Howard Street, Aberdeen, Maryland 21001</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>R. A. Ferris &amp; Co., Inc. 5/2</b>		20c. LOCATION — City or Town, State <b>West Chester, PA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Gary R. DiGianni</b>				22. NAME AND ADDRESS OF FACILITY <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>ASPIRATION</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>STROKE</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>HYPERTENSION</b> Approximate interval between Onset and Death <b>7 days</b> <b>14 days</b> <b>2 months</b> <b>20 yrs</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>CARDIAC ARRHYTHMIA</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dante M. Munk</b>				29c. LICENSE NUMBER <b>D07644</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/1/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DONTE MONARK, MD 622 S. Union Ave Havre de Grace Md</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 01 1995</b>				32. REGISTRAR'S SIGNATURE <b>John A. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14511

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HELEN LEVY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APR 24 1995</b>		3. TIME OF DEATH <b>8:30 AM</b>	
4. SOCIAL SECURITY NUMBER <b>051-10-2950</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 30, 1916</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Ohio</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Vindobona Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Braddock Heights</b>	
9c. COUNTY OF DEATH <b>Frederick</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>	
10c. CITY, TOWN OR LOCATION <b>Braddock Heights</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>Vindobona Nursing Home 6012 Jefferson Blvd</b>	
10f. ZIP CODE <b>21714</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Sales Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Bakery</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John Egress</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Proveck</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Beverly Casey</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4315 Babylon Road, Taneytown, MD 21787</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Baltimore Hebrew Cemetery 4/28</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Swax &amp; Lakerty Myers</i>				22. NAME AND ADDRESS OF FACILITY <b>Myers Funeral Home 91 Willis Street, Westminster, MD 21157</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Probable acute myocardial infarction</b>							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. <b>Anteroselectic cardiovascular disease</b>							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>diabetes hypertension disease</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>W. Myers MD</i>				29c. LICENSE NUMBER <b>016675</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/24/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>WYNE ALONER, BRUNSWICK, MD. 21716</b>							
31. DATE FILED (Month, Day, Year) <b>APR 28 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julia Stueber-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14512

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>ESTELLA M. LARGENT</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>28</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>0535 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>220-07-6028</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3-16-11</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>WASHINGTON Co. Hosp.</b>				9b. CITY/TOWN OR LOCATION OF DEATH <b>Hagerstown</b>		9c. COUNTY OF DEATH <b>WASHINGTON</b>	
10a. STATE <b>PA.</b>		10b. COUNTY <b>GREENE</b>		10c. CITY/TOWN OR LOCATION <b>Carmichaels</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>201 E. Greene St.</b>				10f. ZIP CODE <b>15320</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>—</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>—</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William Milburn</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY BRINKMAN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Sheila Aspey</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11409 Ridge Lane MONROVIA, Md.</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GLADES 5/1/95</b>		20c. LOCATION — City or Town, State <b>Carmichaels, Pa.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Bradley Stewart</b>				22. NAME AND ADDRESS OF FACILITY <b>Stewart Funeral Home 32 S. Second St. OAKLAND, Md. 21550</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>Respiratory Failure</b> DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>Aspiration Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>Cerebrovascular Accident</b> DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Asperia</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>— MD</b>				29c. LICENSE NUMBER <b>D18019</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 28, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>VASANT DATTA, MD 332 MILL ST HAGERSTOWN MD 21740</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 08 1995</b>							

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14513

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KATHLEEN FLORENCE LIGHT</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 23, 1995</b>		3. TIME OF DEATH <b>1:30 a M</b>	
4. SOCIAL SECURITY NUMBER <b>220-10-7624</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 1, 1910</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>MEMORIAL HOSPITAL</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>		8c. COUNTY OF DEATH <b>ALLEGANY</b>	
9. RESIDENCE OF DECEDENT				10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>	
10c. CITY, TOWN OR LOCATION <b>Cumberland</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>706 Avondale Avenue</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Former Owner</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Flower Shop</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William Wingate</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth Gertrude Keller</b>			
19a. INFORMANT'S NAME (Type/Print) <b>William E. Light</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4451 Dunmore Drive; Harrisburg, PA 17112</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Davis Memorial Cemetery</b>		DATE <b>04/29</b>		20c. LOCATION — City or Town, State <b>Cumberland, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. SEPSIS OF UNKNOWN CAUSE</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. _____						Approximate Interval Between Onset and Death <b>6 HOURS</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ALZHEIMER'S deementia, DIABETES MELLITUS</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>James F. Scarpelli</i>		29c. LICENSE NUMBER <b>D 14865</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 24 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Robustiano Barrera-Memorial Hospital Medical Building-Cumberland, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>APR 26 1995</b>				32. REGISTRAR'S SIGNATURE <i>James F. Scarpelli</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


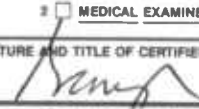





95 14514

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HELIODORE S LANGIS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 19 1995</b>		3. TIME OF DEATH <b>5:20 P M</b>	
4. SOCIAL SECURITY NUMBER <b>217-32-2000</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5/22/08</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital of Cumberland</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland, Md</b>		9c. COUNTY OF DEATH <b>Allegany</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Penna</b>		10b. COUNTY <b>Bedford</b>		10c. CITY, TOWN OR LOCATION <b>Artemas</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>RD 1 Box 11</b>				10f. ZIP CODE <b>17211</b>		10g. CITIZEN OF WHAT COUNTRY? <b>usa</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>manager</b>		16b. KIND OF BUSINESS/INDUSTRY <b>laundry</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Elzer Langis</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Ann Caron</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Theresa Langis</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>RD 1 Box 11 Artemas, Pa, 17211</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>the Fairview Cemetery</b>		DATE <b>4-22-95</b>		20c. LOCATION — City or Town, State <b>Artemas, Pa,</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Dallia Valle FS inc po box 179 Everett, pa, 15537</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>ISCHEMIC CARDIOMYOPATHY</b> DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>5 YEARS</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC RENAL FAILURE</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D 14865</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 20, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. R. Barrera Memorial Hospital Medical Bldg. Cumberland, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>APR 24 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14515

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>THELMA P. LYONS</b>				2. DATE OF DEATH MONTH <b>10</b> DAY <b>15</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>12 17 P M</b>	
4. SOCIAL SECURITY NUMBER <b>251-56-8102</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>56</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>August 27, 1938</b>	
8. BIRTHPLACE (State or Foreign Country) <b>South Carolina</b>				9a. FACILITY NAME (If not institution, give street and number) <b>University of Maryland Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Caroline</b>	
10c. CITY, TOWN OR LOCATION <b>Denton</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>508 Fifth Avenue</b>	
10f. ZIP CODE <b>21629</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>Caucasian</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>8</b>			
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Nurse</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Director of Nursing</b>			
17. FATHER'S NAME (First, Middle, Last) <b>James Alex Pollard</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nora Eliza Knight</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary L. Hardman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>429 Quigley Ave., Willow Grove, Pennsylvania 19090</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Denton Cemetery</b>			
20c. LOCATION — City or Town, State <b>Denton, Maryland</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Randolph C Moore</b>			
22. NAME AND ADDRESS OF FACILITY <b>Moore Funeral Home, P.A. Drawer B, Denton, Maryland 21629</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  a. <b>MULTIPLE TRAUMA</b> DUE TO (OR AS A CONSEQUENCE OF):  b. <b>MOTOR VEHICLE COLLISION</b> DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>1 HR.</b> <b>1 HR.</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>04-15-95</b>			
28b. TIME OF INJURY <b>10 15 A M</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED <b>PASSENGER MOTOR VEHICLE ACCIDENT</b>				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>STREET</b>			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>QUEEN ANNE'S COUNTY</b>				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>D03787</b>			
29d. DATE SIGNED (Month, Day, Year) <b>4/15/95</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)			
31. DATE FILED (Month, Day, Year) <b>APR 18 '95</b>				32. REGISTRAR'S SIGNATURE <b>Jake Davidson-Randall</b>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



95 14516

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ethel Lee				2. DATE OF DEATH MONTH DAY YEAR April 25 1995				3. TIME OF DEATH 8:20 AM			
4. SOCIAL SECURITY NUMBER 184-03-1492				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 95 YRS.		7. DATE OF BIRTH (Month, Day, Year) 02-11-1900		8. BIRTHPLACE (State or Foreign Country) Pennsylvania	
9a. FACILITY NAME (If not institution, give street and number) 366 Coyote Corner Road						9b. CITY, TOWN OR LOCATION OF DEATH Chesapeake City			9c. COUNTY OF DEATH Cecil		
10a. STATE MD						10b. COUNTY Cecil			10c. CITY, TOWN OR LOCATION Chesapeake City		
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO						10e. STREET AND NUMBER 366 Coyote Corner Road			10f. ZIP CODE 21915		
10g. CITIZEN OF WHAT COUNTRY? USA						11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:						14. RACE — American Indian, Black, White, etc. Specify: Black			15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Trimmer						16b. KIND OF BUSINESS/INDUSTRY Clothing Manufacturer					
17. FATHER'S NAME (First, Middle, Last) George Pennick						18. MOTHER'S NAME (First, Middle, Maiden Surname) Janice Gibbs					
19a. INFORMANT'S NAME (Type/Print) James Carter						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 917 E. Woodland St., Philadelphia, PA 19138					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)						20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fairview Cemetery 5/1/95 Willow Grove, PA					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Chris D. Congo</i>						22. NAME AND ADDRESS OF FACILITY Congo Funeral Home P.O. Box 2593, Wilm., DE 19805					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure											
DUE TO (OR AS A CONSEQUENCE OF):											
b. ASCVD											
DUE TO (OR AS A CONSEQUENCE OF):											
c.											
DUE TO (OR AS A CONSEQUENCE OF):											
d.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO											
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Henry Farkas MD</i>				29c. LICENSE NUMBER D15314		29d. DATE SIGNED (Month, Day, Year) April 25, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Henry Farkas Northern Chesapeake Hospice, Inc. 239 S. Bridge St. Elkton, MD 21921											
31. DATE FILED (Month, Day, Year) APR 28 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14517

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CLARA VIRGINIA LUSBY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 25, 1995</b>		3. TIME OF DEATH <b>5:45 P M</b>	
4. SOCIAL SECURITY NUMBER <b>218-54-8368</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6-16-1910</b> June	
9a. FACILITY NAME (If not institution, give street and number) <b>PHYSICIANS MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>LA PLATA</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Charles</b>		10c. CITY, TOWN OR LOCATION <b>Hughesville</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>12550 Grosstown Road</b>				10f. ZIP CODE <b>20637</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Domestic</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Richard Bradford Seay</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Annie Ferguson Gailbraithe</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Julia A. Branson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12630 Grosstown Rd., Hughesville, Md. 20637</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Ft. Lincoln Cemetery</b>		OATE <b>4/28</b>		20c. LOCATION — City or Town, State <b>Brentwood, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mark G. Brohawn</i> <b>Mark G. Brohawn</b>		M00053		22. NAME AND ADDRESS OF FACILITY <b>The Hunt Funeral Home, Inc.</b> <b>P.O. Box 156, Waldorf, Md. 20604</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic Cardiovascular Disease</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>b. Diabetes Mellitus</b>  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <b>years</b> <b>years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Julia A. Branson</i> <b>Julia A. Branson</b>				29c. LICENSE NUMBER <b>D-27348</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/26/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>HOWARD M. HAFT, MD. 700 OLDE LINE CENTER SUITE 100 WALDORF, MARYLAND 20602</b>							
31. DATE FILED (Month, Day, Year) <b>APR 28 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julia A. Branson</i> <b>Julia A. Branson</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14518

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Frances Augusta Lyans				2. DATE OF DEATH MONTH DAY YEAR April 27, 1995				3. TIME OF DEATH 1655 P M			
4. SOCIAL SECURITY NUMBER 390 09 4181		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 100 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) December 3, 1894		8. BIRTHPLACE (State or Foreign Country) Iowa	
9a. FACILITY NAME (If not institution, give street and number) Calvert Memorial Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Prince Frederick			9c. COUNTY OF DEATH Calvert		
RESIDENCE OF DECEDENT											
10a. STATE Maryland			10b. COUNTY Calvert			10c. CITY, TOWN OR LOCATION Port Republic			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 2184 Cedar Road						10f. ZIP CODE 20676			10g. CITIZEN OF WHAT COUNTRY? United States		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) self employed				18b. KIND OF BUSINESS/INDUSTRY photo finishing			
17. FATHER'S NAME (First, Middle, Last) John Baptist Ambs						18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Frances Hoppe					
19a. INFORMANT'S NAME (Type/Print) Mrs. John Axley						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 184 Port Republic Maryland 20676					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Funeral Service Alexandria Virginia April 28, 1995				20c. LOCATION — City or Town, State Alexandria Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE B. Rausch						22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home Port Republic Maryland 20676					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebro Vascular Accident											
DUE TO (OR AS A CONSEQUENCE OF):											
b. Hypertension											
DUE TO (OR AS A CONSEQUENCE OF):											
c. _____											
DUE TO (OR AS A CONSEQUENCE OF):											
d. _____											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO											
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Robert J. Schlager MD						29c. LICENSE NUMBER D16823			29d. DATE SIGNED (Month, Day, Year) 4-28-95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert J. Schlager, M.D. 110 Hospital Rd. Prince Frederick, MD											
31. DATE FILED (Month, Day, Year) APR 28 1995				32. REGISTRAR'S SIGNATURE Michael Rodall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

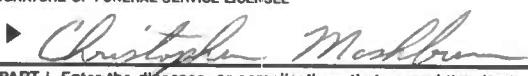


IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14519

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Catherine Elizabeth McDonald</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 21 1995</b>		3. TIME OF DEATH <b>10:15 A. M.</b>	
4. SOCIAL SECURITY NUMBER <b>577-60-4745</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>January 5, 1909</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>257 Congressional Lane #602</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Rockville</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>257 Congressional Lane #602</b>				10f. ZIP CODE <b>20852</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Administrative Assistant</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Federal Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Jeremiah J. McDonald</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Catherine E. Nichols</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Father Eustace J. McDonald</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>251 South Morley Baltimore, Maryland 21229</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery 4/24/95</b>		20c. LOCATION — City or Town, State <b>Silver Spring, Maryland</b>		22. NAME AND ADDRESS OF FACILITY <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebral Vascular Accident</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Atrial Fibrillation</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Arteriosclerotic Heart Disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. _____</b> Approximate Interval Between Onset and Death <b>Immediate</b> Years			
23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>D 00946</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 23, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Wilfred R. Ehrmantraut, M.D. 11125 Rockville Pike Rockville, Maryland 20852</b>							
31. DATE FILED (Month, Day, Year) <b>APR 25 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Amend #1, 4/25/95

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

MRT Montgomery County 95-114520

1. DECEDENT'S NAME (First, Middle, Last) LOUIS messersmith MASSERSMITH-				2. DATE OF DEATH MONTH DAY YEAR APRIL 21 1995		3. TIME OF DEATH 2:45 AM	
4. SOCIAL SECURITY NUMBER 215-02-9704		5. SEX XX M 2 F		6. AGE (In yrs. last birthday) 27 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 21, 1967	
8. BIRTHPLACE (State or Foreign Country) Washington, D.C.				9a. FACILITY NAME (If not institution, give street and number) I-695 SOUTH BOUND		9b. CITY, TOWN OR LOCATION OF DEATH SPARROWS POINT	
9c. COUNTY OF DEATH BALTIMORE				10a. STATE Maryland			
10b. COUNTY Prince George's				10c. CITY, TOWN OR LOCATION Laurel			
10d. INSIDE CITY LIMITS? XX YES 2 NO				10e. STREET AND NUMBER 8301 Ashford Blvd., #511			
10f. ZIP CODE 20707				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Auto Body Repair		16b. KIND OF BUSINESS/INDUSTRY Private			
17. FATHER'S NAME (First, Middle, Last) Floyd A. Messersmith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Brenda L. Lynch			
19a. INFORMANT'S NAME (Type/Print) Maria K. Messersmith (wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland National Memorial Park 4/24/95		20c. LOCATION — City or Town, State Laurel, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald V. Borgwardt	
22. NAME AND ADDRESS OF FACILITY Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple Injuries DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Roadway					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 4-21-95		28b. TIME OF INJURY 0228 M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED Driver - Auto - Auto collision		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Roadway		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) I-695 South			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) APRIL 21, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) APR 25 1995		32. REGISTRAR'S SIGNATURE John Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



4

95 14521

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Catherine Ann Malcolm</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 22, 1995</i>		3. TIME OF DEATH M <i>2200</i>	
4. SOCIAL SECURITY NUMBER <i>577-30-5298</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>68</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>May 6, 1926</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Virginia</i>				9a. FACILITY NAME (If not institution, give street and number) <i>6408 Riggs Road</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Chillum</i>	
9c. COUNTY OF DEATH <i>Prince George's</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Prince George's</i>	
10c. CITY, TOWN OR LOCATION <i>Chillum</i>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>6408 Riggs Road</i>	
10f. ZIP CODE <i>20783</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>2</i> College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Administrative Secretary</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Nursing Home</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Roger Allan</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Hanna Unknown</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Susan E. Lucas</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>10710 Timberline Drive Upper Marlboro, Maryland 20772</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Gate of Heaven Cemetery 4/26/95</i>		20c. LOCATION — City or Town, State <i>Silver Spring, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Steven D. Stord</i>				22. NAME AND ADDRESS OF FACILITY <i>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arteriosclerotic cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Major depression</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i>				29c. LICENSE NUMBER <i>21230</i>		29d. DATE SIGNED (Month, Day, Year) <i>April 22, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) <i>Augusto P. Rodriguez MD, 5009 Baydurn Ct. Cp Sp Md 20748</i>							
31. DATE FILED (Month, Day, Year) <i>APR 25 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14522

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EDNA MARY McPADDEN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 22, 1995</b>				3. TIME OF DEATH HOURS MIN. <b>1:53 A M</b>	
4. SOCIAL SECURITY NUMBER <b>123-12-7467</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 10, 1917</b>		8. BIRTHPLACE (State or Foreign Country) <b>Massachusetts</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Holy Cross Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>				9c. COUNTY OF DEATH <b>Montgomery</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2201 Greenery Lane Apt. 104</b>				10f. ZIP CODE <b>20906</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>12</b> College (1-4 or 5+) <b>Waitress</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Waitress</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Restaurant</b>		
17. FATHER'S NAME (First, Middle, Last) <b>Albert Orzulak</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Antonia Majka</b>					
19a. INFORMANT'S NAME (Type/Print) <b>William Patrick McPadden, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13201 Topsfield Court Herndon, Virginia 22071</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery 4/25/95 Silver Spring, Maryland</b>			20c. LOCATION — City or Town, State		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Christopher Mashburn</i>				22. NAME AND ADDRESS OF FACILITY <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acute Extensive Anterior Myocardial Infarct Hours</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Diffuse Atherosclerosis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Herman Segal</i>		29c. LICENSE NUMBER <b>D 25808</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/22/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>10313 Georgia Ave S. Silver Spring Md Herman Segal, M.D.</b>									
31. DATE FILED (Month, Day, Year) <b>APR 26 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julia Drucker-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14523

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Gladys Marguerite Magwood				2. DATE OF DEATH MONTH DAY YEAR April 21 1995		3. TIME OF DEATH 3:33 P M	
4. SOCIAL SECURITY NUMBER 106-22-6400		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 8, 1930	
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 11215 Oakleaf Drive				10f. ZIP CODE 20901		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Afro-American	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 6		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Administrator		16b. KIND OF BUSINESS/INDUSTRY Mont. Co. Public Schools			
17. FATHER'S NAME (First, Middle, Last) William Zachariah McGill				18. MOTHER'S NAME (First, Middle, Maiden Surname) Izetta Pierce			
19a. INFORMANT'S NAME (Type/Print) Colette M. Magwood				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 621 Sonata Way, Silver Spring, Maryland 20901			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Magnolia Cemetery 4/28		20c. LOCATION — City or Town, State Charleston, South Carolina			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF):					
		c. DIABETES MELLITUS DUE TO (OR AS A CONSEQUENCE OF):					
		d. DIABETES MELLITUS					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER B93547		29d. DATE SIGNED (Month, Day, Year) 4/27/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Alan Oboler, M.D. 8830 Cameron Street, Silver Spring, Maryland 20910							
31. DATE FILED (Month, Day, Year) APR 26 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14524

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Evelyn M. McCormack				2. DATE OF DEATH MONTH DAY YEAR April 20 1995		3. TIME OF DEATH 11:10 A M	
4. SOCIAL SECURITY NUMBER 579-88-3793		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 22, 1923	
8. BIRTHPLACE (State or Foreign Country) Jamaica				9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 1916 Rosemary Hill Drive Apt. T1	
10f. ZIP CODE 20910				10g. CITIZEN OF WHAT COUNTRY? Jamaica		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: Black				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 0			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Claude Rowe				18. MOTHER'S NAME (First, Middle, Maiden Surname) Josephine Sinclair			
19a. INFORMANT'S NAME (Type/Print) Carlton Hall				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10103 Kindross Avenue, Silver Spring, Maryland 20901			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) George Washington Cemetery 4/25			
20c. LOCATION — City or Town, State Adelphi, Maryland				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>			
22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  a. <i>Neurogenic shock</i> DUE TO (OR AS A CONSEQUENCE OF):  b. <i>Massive intracranial hemorrhage</i> DUE TO (OR AS A CONSEQUENCE OF):  c. <i>Cerebral edema &amp; shift</i> DUE TO (OR AS A CONSEQUENCE OF):  d.  Approximate Interval Between Onset and Death 48  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER A34860			
29d. DATE SIGNED (Month, Day, Year) 4/20/95				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Oleg Shpak, MD 5630 Shields Drive Bethesda, Maryland 20817			
31. DATE FILED (Month, Day, Year) APR 26 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ask MD 24

95 14525

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Gerard J. Marks				2. DATE OF DEATH MONTH April DAY 24 YEAR 1995		3. TIME OF DEATH 2:50 A M	
4. SOCIAL SECURITY NUMBER 118-03-4859		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 17, 1915	
9a. FACILITY NAME (If not institution, give street and number) 9403 Stateside Court				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 9403 Stateside Court				10f. ZIP CODE 20903		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer		16b. KIND OF BUSINESS/INDUSTRY U.S. Government			
17. FATHER'S NAME (First, Middle, Last) Patrick Marks				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anne Murphy			
19a. INFORMANT'S NAME (Type/Print) Virginia S. Marks				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9403 Stateside Court, Silver Spring, Maryland 20903			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 4/27		20c. LOCATION — City or Town, State Silver Spring, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas Gugen</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Colon Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 2 1/2 yrs
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Brain & lung metastases Coronary Artery Disease DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D10620		29d. DATE SIGNED (Month, Day, Year) 4/24/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) EDGAR H. LEVIN, 9801 GEORGETOWN AVE.							
31. DATE FILED (Month, Day, Year) APR 26 1995		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 14526

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert Knox McCormac, Jr.				2. DATE OF DEATH MONTH DAY YEAR April 22, 1995		3. TIME OF DEATH 10:30 A M	
4. SOCIAL SECURITY NUMBER 578-07-7341		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 24, 1914	
9a. FACILITY NAME (If not institution, give street and number) Arcola Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 407 Brewster Avenue				10f. ZIP CODE 20901		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Picture Editor		16b. KIND OF BUSINESS/INDUSTRY Photography	
17. FATHER'S NAME (First, Middle, Last) Robert K. McCormac, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sadie Childs			
19a. INFORMANT'S NAME (Type/Print) Frances M. McCormac				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 Brewster Avenue Silver Spring, MD 20901			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Olivet Cemetery 4/26/95		20c. LOCATION — City or Town, State Washington D.C.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Steven D. Stord</i>				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd.W., Sil.Spr. MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multi Stroke Dementia DUE TO (OR AS A CONSEQUENCE OF): b. Generalized Atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>George F. Sengstack M.D.</i>				29c. LICENSE NUMBER D 12121		29d. DATE SIGNED (Month, Day, Year) 4-25-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George F. Sengstack, M.D. 3929 Ferrara Drive, Wheaton, MD 20906							
31. DATE FILED (Month, Day, Year) APR 27 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
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TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
CERTIFICATE OF DEATH											
REG. NO.											
1. DECEDENT'S NAME (First, Middle, Last) Eleanore Agnes McAllister				2. DATE OF DEATH MONTH DAY YEAR April 28, 1995		3. TIME OF DEATH 2:00 AM					
4. SOCIAL SECURITY NUMBER 578-48-2110		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 20, 1916		8. BIRTHPLACE (State or Foreign Country) Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Frederick			9c. COUNTY OF DEATH Frederick				
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 5758 Box Elder Court				10f. ZIP CODE 21701		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Register Nurse			16b. KIND OF BUSINESS/INDUSTRY Health Care				
17. FATHER'S NAME (First, Middle, Last) James Dooley				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anne Murphy							
19a. INFORMANT'S NAME (Type/Print) Cornelius H. McAllister, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3520 Big Woods Road, Ijamsville, Md. 21754							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Union Hill Cem., May 2, 1995			DATE		20c. LOCATION — City or Town, State Konnott Square, Pa.				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Richard E. Gray M00255				22. NAME AND ADDRESS OF FACILITY Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval between Onset and Death 3 weeks			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cancer of the Esophagus								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Casper E. Cline III MD						29c. LICENSE NUMBER D 16428		29d. DATE SIGNED (Month, Day, Year) 4/28/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) Dr. Casper E. Cline III MD 300 West Ninth Street, Frederick, Maryland 21701											
31. DATE FILED (Month, Day, Year) MAY 01 1995				32. REGISTRAR'S SIGNATURE John A. ...							



95 14528

10 1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>PEARL B ELL MOODY</b>				2. DATE OF DEATH MONTH <b>Apr</b> DAY <b>19</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>8:40 am</b>	
4. SOCIAL SECURITY NUMBER <b>241-26-5428</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Apr. 6, 1912</b>	
8. BIRTHPLACE (State or Foreign Country) <b>North Carolina</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>Saint Joseph Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson, Maryland</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Joppa</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10a. STREET AND NUMBER <b>1524 Philadelphia Road</b>				10f. ZIP CODE <b>21085</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Tyson Calvin Wilmoth</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Katherine (u/k) Caudle</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dorothy Smallwood</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1522 Philadelphia Road, Joppa, Md. 21085</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>White Oak Cemetery</b>		DATE <b>4/22/95</b>		20c. LOCATION — City or Town, State <b>Thurmond, NC</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>BOWEL INFARCTION</b> DUE TO (OR AS A CONSEQUENCE OF): <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Beatriz P. Dizon M.D.</b>				29c. LICENSE NUMBER <b>D 16492</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 19, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>BEATRIZ P. DIZON, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204</b>							
31. DATE FILED (Month, Day, Year) <b>APR 20 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Town, Maryland

East Coast Medical Center

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BOWEL INFARCTION

ARTERIOSCLECTIC CARDIOVASCULAR DISEASE

12 18 85

BEATRICE E. CLON, M.D. 1650 YORK ROAD, TOWSON, MARYLAND 21204

25 12 1984

95 14529

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>LASHAWN MOSES</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>20</b> YEAR <b>95</b>		3. TIME OF DEATH <b>1707</b> M	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>0</b> YRS.	IF UNDER 1 YEAR MONTHS <b>3</b> DAYS <b>3</b>	IF UNDER 24 HRS. HOURS <b>3</b> MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>April 17 1995</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9. COUNTY OF DEATH			
9a. FACILITY NAME (If not institution, give street and number) <b>ST AGNES HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>PRINCE GEORGE'S</b>		10c. CITY, TOWN OR LOCATION <b>CANDOVER HILLS</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6727 DORMAN STREET</b>				10f. ZIP CODE <b>20784</b>		10g. CITIZEN OF WHAT COUNTRY? <b>US</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>DEBRA MOSES</b>			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6727 DORMAN STREET, CANDOVER HILLS, MD 20784</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Jackie D. Shannon</b>				22. NAME AND ADDRESS OF FACILITY <b>HUBBARD FUNERAL HOME, INC. 4107 WICKENS AVENUE-BALTIMORE, MD 21229</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>PULMONARY HEMORRHAGE</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>RESPIRATORY DISTRESS SYNDROME</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>EXULOME PREMATURE</b> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>24 HOURS</b> <b>MINUTES</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>TRACHEOBronchial Hemorrhage</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <b>1</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Howard J. Birenbaum, MD</b>				29c. LICENSE NUMBER <b>124875</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 21, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>HOWARD J. BIRENBAUM, MD</b>				31. DATE FILED (Month, Day, Year) <b>MAY 11 1995</b>			
32. REGISTRAR'S SIGNATURE <b>John D. Hatcher-Randall</b>				33. DATE FILED (Month, Day, Year)			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14530

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Alice Christine Moffatt				2. DATE OF DEATH MONTH DAY YEAR April 25, 1995		3. TIME OF DEATH 900 A. M.	
4. SOCIAL SECURITY NUMBER 213-22-4216		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 17, 1904	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 25 State Street North		9b. CITY, TOWN OR LOCATION OF DEATH Lonaconing	
9c. COUNTY OF DEATH Allegany				10a. STATE Maryland		10b. COUNTY Allegany	
10c. CITY, TOWN OR LOCATION Lonaconing				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 25 State Street North	
10f. ZIP CODE 21539				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) George T. McCormick				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lora Fazenbaker			
19a. INFORMANT'S NAME (Type/Print) Eunice E. Jenkins				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 507 Grandview Drive, Frostburg, Md. 21532			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Frostburg Mem. Park April 27, 1995			
20c. LOCATION — City or Town, State Frostburg, Md.				21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jane E. McKen			
22. NAME AND ADDRESS OF FACILITY Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539				23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MYOCARDIAL INFARCTION Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): ARTERIOSCLEROTIC CARDIOSCLEROTIC DISEASE b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval between Onset and Death 80min			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Donald F. Manger MD			
29c. LICENSE NUMBER D09271				29d. DATE SIGNED (Month, Day, Year) 4/27/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD F. MANGER MD R1230X 878 Cumberland Md 21502				31. DATE FILED (Month, Day, Year) APR 27 1995			
32. REGISTRAR'S SIGNATURE John H. ...							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14531

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mina Elizabeth McCarty				2. DATE OF DEATH MONTH DAY YEAR April 27, 1995		3. TIME OF DEATH 10:40 a.m.	
4. SOCIAL SECURITY NUMBER 219-20-4782		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUG 6, 1908	
8. FACILITY NAME (If not institution, give street and number) 8931 Corner Road				9. CITY, TOWN OR LOCATION OF DEATH Hancock		10. COUNTY OF DEATH Washington	
10a. STATE MD		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hancock		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8931 Corner Road				10f. ZIP CODE 21750		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Lewis Weller				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Hull			
19a. INFORMANT'S NAME (Type/Print) Mildred E. Smith				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 904 James St. Berkeley Springs, WV 25411			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Orchard Ridge Cemetery 4/30/95		20c. LOCATION — City or Town, State Hancock, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert S. Hull</i>				22. NAME AND ADDRESS OF FACILITY Grove Funeral Home P.O. Box 368 Hancock, MD 21750			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Depression, severe, with poor oral intake DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 3 weeks
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert S. Hull</i>		29c. LICENSE NUMBER D04359		29d. DATE SIGNED (Month, Day, Year) 5/1/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert Hull, MD 1459 Potomac Ave Hagerstown MD 21742							
31. DATE FILED (Month, Day, Year) MAY 10 1995		32. REGISTRAR'S SIGNATURE <i>John A. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

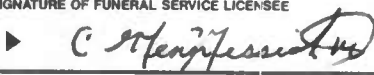


IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14532

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Catherine Adkins Martin</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>24</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>2020 Hr</b>	
4. SOCIAL SECURITY NUMBER <b>215-26-2666</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>66</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>August, 28, 1928</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1004 N. Division St.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury, Md.</b>		9c. COUNTY OF DEATH <b>Wicomico</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Wicomico</b>		10c. CITY, TOWN OR LOCATION <b>Salisbury</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1004 N. Division St.</b>				10f. ZIP CODE <b>21801</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Fredrick K. Adkins</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Blanche A. Penewell</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ccstal Hospice</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21801 2604 Old Ocean City Rd Salisbury, Md</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parsons Cem. APRIL 27-95</b>		20c. LOCATION — City or Town, State <b>Salisbury, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>M00416</b>				22. NAME AND ADDRESS OF FACILITY <b>Messick Funeral Home PO Box 61 Bivalve, Md. 21814</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>CANCER of the brain (from lung)</b>					
		b. <b>Disease spread from lung CANCER</b>					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. <b></b>					
		d. <b></b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>MD</b>				29c. LICENSE NUMBER <b>D36128</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/25/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>APR 25 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EARL RAYMOND MCNEIL JR</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 23 1995</b>		3. TIME OF DEATH <b>1:26 PM</b>	
4. SOCIAL SECURITY NUMBER <b>029-36-6325</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>46</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 14 1948</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA REGIONAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Somerset</b>		10c. CITY, TOWN OR LOCATION <b>Princess Anne</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>32562 West Post Office Road</b>				10f. ZIP CODE <b>21853</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Vietnam War</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Auto Mechanic</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Automobile Repair</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Earl R. McNeil, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Thelma Greenwood</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Barbara McNeil</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>32562 West Post Office Road, Princess Anne, Md.</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Beechwood Cemetery</b>		OATE <b>4/27</b>		20c. LOCATION — City or Town, State <b>Princess Anne, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James E. McNeil</i> M00295				22. NAME AND ADDRESS OF FACILITY <b>Hinman Funeral Home Princess Anne, Md. 21853</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>4-23-95</b>		28b. TIME OF INJURY <b>12:00 PM</b>	
28c. INJURY AT WORK? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED <b>FIREFIGHTER COMPLAINED OF WEAKNESS AND DIZZINESS WHILE FIGHTING A FIRE</b>			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>WOODS</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>PEGGY NECK RD. EDEN, MARYLAND</b>			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King</i>				29c. LICENSE NUMBER <b>O.C.M.E</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 24, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>THEODORE M. KING 1 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>APR 26 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Paulsen-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Printed on the back of the page



95 14534

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Baby Boy Moore</i>				2. DATE OF DEATH MONTH DAY YEAR <i>05 05 95</i>		3. TIME OF DEATH <i>250 P</i> M	
4. SOCIAL SECURITY NUMBER		5. SEX <i>1 M 2 F</i>	6. AGE (In yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <i>05-05-95</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Southern MD Hospital Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Clinton</i>		9c. COUNTY OF DEATH <i>Prince Georges</i>	
10a. STATE <i>Md.</i>		10b. COUNTY <i>Calvert</i>		10c. CITY, TOWN OR LOCATION <i>Lusby</i>		10d. INSIDE CITY LIMITS? <i>1 YES 2 NO</i>	
10a. STREET AND NUMBER <i>427 Dogwood Drive</i>				10f. ZIP CODE <i>20657</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <i>1 Never Married 2 Married 3 Widowed 4 Divorced</i>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <i>1 YES 2 NO</i> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1 YES 2 NO Specify:</i>		14. RACE — American Indian, Black, White, etc. Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <i>Lewis Edward Moore</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Michelle May Moore</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Michelle Moore</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>427 Dogwood Dr. Lusby Md 20657</i>			
20a. METHOD OF DISPOSITION <i>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</i>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>▶</i>				22. NAME AND ADDRESS OF FACILITY			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Fetal prematurity</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Chorioamnionitis</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <i>1 YES 2 NO</i>
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <i>1 YES 2 NO N/A</i>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <i>1 YES 2 NO</i>		26. PLACE OF DEATH (Check only one) HOSPITAL: <i>1 Inpatient 2 ER/Outpatient 3 DOA</i> OTHER: <i>4 Nursing Home 5 Residence 6 Other (Specify)</i>					
27. MANNER OF DEATH <i>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</i>		28a. DATE OF INJURY (Month, Day, Year) <i>N/A</i>		28b. TIME OF INJURY <i>N/A M</i>		28c. INJURY AT WORK? <i>N/A</i> <i>1 YES 2 NO</i>	
		28d. DESCRIBE HOW INJURY OCCURRED <i>N/A</i>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>N/A</i>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>N/A</i>	
29a. CERTIFIER (Check only one) <i>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i> <i>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i>							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ronald T. [Signature]</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <i>▶ 5/5/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>11345 Pembroke Rd. #111 WILDORE, MD 20603</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 11 1995</i>		32. REGISTRAR'S SIGNATURE <i>John [Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14535

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Baby Girl Moore</b>				2. DATE OF DEATH MONTH DAY YEAR <b>05 05 95</b>		3. TIME OF DEATH <b>2:50 p M</b>	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS <b>1 28</b>		7. DATE OF BIRTH (Month, Day, Year) <b>05-05-95</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Southern MD Hospital Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Clinton</b>		9c. COUNTY OF DEATH <b>Prince Georges</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Calvert</b>		10c. CITY, TOWN OR LOCATION <b>Lusby</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>427 Dogwood Drive</b>				10f. ZIP CODE <b>20657</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Lewis Edward moore</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Michelle May moore</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Michelle Moore</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>427 Dogwood Drive Lusby Md. 20657</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <b>Hospital</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>▶</b>				22. NAME AND ADDRESS OF FACILITY			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Fetal prematurity</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Chorioamnionitis</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO <b>NIA</b>			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>NIA</b>		28b. TIME OF INJURY <b>NIA M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO <b>NIA</b>	
		28d. DESCRIBE HOW INJURY OCCURED <b>NIA</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>NIA</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>NIA</b>	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Ronald T. Zulawski MD</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>5/5/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Penbrook So #111 11245 WALDORF, MD 20603</b>							
31. DATE Filled (Month, Day, Year) <b>MAY 11 1995</b>							

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



95 14536

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY CAROLINE MCKINNEY				2. DATE OF DEATH MONTH DAY YEAR APR. 30, 1995		3. TIME OF DEATH 1625 M	
4. SOCIAL SECURITY NUMBER 217-09-1797		5. SEX <input type="checkbox"/> Male <input checked="" type="checkbox"/> FEMALE		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sep 18, 1908	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) CARROLL COUNTY GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH WESTMINSTER	
9c. COUNTY OF DEATH CARROLL				10a. STATE MD		10b. COUNTY CARROLL	
10c. CITY, TOWN OR LOCATION UNION BRIDGE				10d. INSIDE CITY LIMITS <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 103 LIGHTNER ST.	
10f. ZIP CODE 21791				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES NO				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: NO			
14. RACE — American Indian, Black, White, etc. Specify: WHITE				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER			
16. KIND OF BUSINESS/INDUSTRY OWN HOME				17. FATHER'S NAME (First, Middle, Last) GEORGE DELPHEY			
18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY ELLEN DAYHOFF				19a. INFORMANT'S NAME (Type/Print) SHIRLEY A. JOHNSON			
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 LIGHTNER ST. UNION BRIDGE MD 21791				20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MOUNTAIN VIEW CEMETERY 5/3				20c. LOCATION — City or Town, State UNION BRIDGE, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Catherine D. Hartzler</i>				22. NAME AND ADDRESS OF FACILITY D. D. HARTZLER & SONS UNION BRIDGE, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia &amp; Congestive heart failure</i> Approximate Interval Between Onset and Death Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Heart failure</i> b. <i>arteriosclerotic cardiovascular disease</i> c. <i>arteriosclerotic cardiovascular disease</i> d. <i>arteriosclerotic cardiovascular disease</i> yes							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CHF, diabetes mellitus, osteoarthritis</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ephraim Barzaga</i>			
29c. LICENSE NUMBER D14992				29d. DATE SIGNED (Month, Day, Year) 5-1-95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) EPHRAIM BARZAGA, M.D. NEW WINDSOR, MD 21776							
31. DATE FILED (Month, Day, Year) MAY 02 1995				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

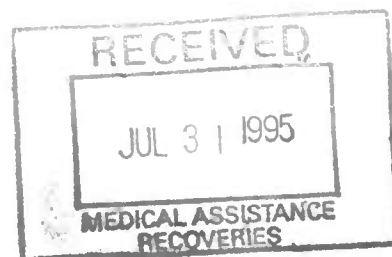
P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14537

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Stephanie Grace Miller				2. DATE OF DEATH MONTH April DAY 27 YEAR 1995		3. TIME OF DEATH 3:27PM M	
4. SOCIAL SECURITY NUMBER 229-19-2313		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 16 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 2, 1978	
9a. FACILITY NAME (If not institution, give street and number) Intersection of Rt. 26 & South St.		9b. CITY, TOWN OR LOCATION OF DEATH Libertytown		9c. COUNTY OF DEATH Frederick		8. BIRTHPLACE (State or Foreign Country) Virginia	
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7823 Chestnut Grove Rd.				10f. ZIP CODE 21701		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) student		16b. KIND OF BUSINESS/INDUSTRY high school			
17. FATHER'S NAME (First, Middle, Last) Lawrence Miller				18. MOTHER'S NAME (First, Middle, Maiden Surname) Donna Reeves			
19a. INFORMANT'S NAME (Type/Print) Donna R. Bowman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7823 Chestnut Grove Rd. Frederick, MD 21701			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremation, Inc. 5/1		20c. LOCATION — City or Town, State Hampstead, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Catherine O. Hartzler</i>				22. NAME AND ADDRESS OF FACILITY D.D. Hartzler & Sons Libertytown, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Injuries DUE TO (OR AS A CONSEQUENCE OF): b. Motor Vehicle Accident DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Roadway					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Undetermined		28a. DATE OF INJURY (Month, Day, Year) 4/27/95		28b. TIME OF INJURY 3:26PM		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED motor Vehicle Accident		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Rt 26 & South St. Roadway		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Libertytown.	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Andrew Z. [Signature]</i>				29c. LICENSE NUMBER D35164		29d. DATE SIGNED (Month, Day, Year) 4/28/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Andrew Z. [Signature], Jr., MD P.O. Box 369 Walkersville, MD							
31. DATE FILED (Month, Day, Year) MAY 02 1995				32. REGISTRAR'S SIGNATURE <i>J. [Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Amended, item #4, Harford County S.B.

95 14538

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Louise D. Needy</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 27, 1995</b>		3. TIME OF DEATH <b>8:40 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>212-07-2700</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>90</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 4, 1904</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>103 Donzen Drive Apt. E</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Bel Air</b>		9c. COUNTY OF DEATH <b>Harford</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Bel Air</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>103 Donzen Drive Apt. E</b>				10f. ZIP CODE <b>21014</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>In home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Adolph Droscher</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>UNK</b>			
19a. INFORMANT'S NAME (Type/Print) <b>William G. Kemp</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>141 E. Main Street, Elkton, Maryland 21921</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Darlington Cemetery</b>		DATE <b>5/3</b>		20c. LOCATION — City or Town, State <b>Darlington, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Kirsten Amy Unglesbee</b>				22. NAME AND ADDRESS OF FACILITY <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>Cardiac Arrest</b> DUE TO (OR AS A CONSEQUENCE OF):  b. <b>Coronary insufficiency</b> DUE TO (OR AS A CONSEQUENCE OF):  c. <b>Old Age</b> DUE TO (OR AS A CONSEQUENCE OF):  d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes mellitus</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Phillip Heuman, M.D.</b>				29c. LICENSE NUMBER <b>204914</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 28, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Phillip Heuman, M.D. 307 Hickory Avenue, Bel Air, Maryland 21014</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 01 1995</b>		32. REGISTRAR'S SIGNATURE <b>Johanna...</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14539

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Ethel Franklyn Nelson</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 3, 1995</b>		3. TIME OF DEATH M <b>19:04</b>	
4. SOCIAL SECURITY NUMBER <b>212 10 0170</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 16 1912</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Calvert Memorial Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Prince Frederick</b>	
9c. COUNTY OF DEATH <b>Calvert</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Calvert</b>	
10c. CITY, TOWN OR LOCATION <b>St. Leonard</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>Box 33 Ave. B</b>	
10f. ZIP CODE <b>20685</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>telephone operator</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Government</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Franklyn O'Hara</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lola Mae Wilson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Wayne Nelson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4008 Welsley Lane Bowie Maryland 20715</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>Waters Memorial Cemetery April 7, 1995</b>			
20c. LOCATION — City or Town, State <b>St. Leonard, Maryland</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>B. Rausch</b>			
22. NAME AND ADDRESS OF FACILITY <b>Rausch Funeral Home</b> <b>4405 Broomes Is. Rd. Port Republic MD</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CVA.</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF): <b>ASCVD, CHF.</b> <b>D.M.</b> <b>FX Left hip.</b>			
24. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				25. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
26. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				27. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
28. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				29. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>April 3, 1995</b>			
28b. TIME OF INJURY M <b>19:04</b>				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. K. Yazdani</b>				29c. LICENSE NUMBER <b>D17168</b>			
29d. DATE SIGNED (Month/Day/Year) <b>04/03/95</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. K. Yazdani Prince Frederick, MD.</b>			
31. DATE FILED (Month, Day, Year) <b>APR - 6 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

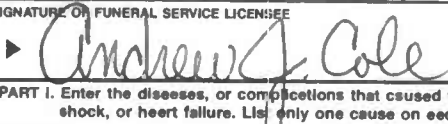

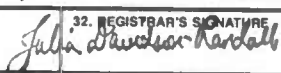
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14540

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Elizabeth V O'Brien</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>25</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>2:40 A M</b>	
4. SOCIAL SECURITY NUMBER <b>578-24-0522</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 24, 1909</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>11409 Kenton Place</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Wheaton</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Wheaton</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>11409 Kenton Place</b>				10f. ZIP CODE <b>20902</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Supervisor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>County Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George William Franklin</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Gussie L. Green</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Betty O'Brien Linthicum</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11409 Kenton Place, Wheaton, MD 20902</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery 4/28/95</b>		20c. LOCATION — City or Town, State <b>Silver Spring, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Sil. Spr. MD 20901</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Pancreatic Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D 43083</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 26, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>George A. Sotos, M.D. 9707 Medical Center Dr. #300, Rockville, MD 20850</b>							
31. DATE FILED (Month, Day, Year) <b>APR 28 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14541

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES EDWARD OWENS</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>21</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>1:55 PM</b>	
4. SOCIAL SECURITY NUMBER <b>218-12-5459</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb 3, 1919</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>WV</b>		10b. COUNTY <b>Mineral</b>		10c. CITY, TOWN OR LOCATION <b>Ridgeley</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>Route 2 Box 333</b>				10f. ZIP CODE <b>26753</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Nursing Assistant</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Hospital</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Ollie Edward Owens</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Catherine Agnes (Fair)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ollie J. Owens</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>100 Center Street Apt. 2 Kingwood, WV 26537</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Maplewood Cemetery</b>		DATE <b>04/24</b>		20c. LOCATION — City or Town, State <b>Kingwood, WV</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Metastatic colon carcinoma</b> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		c. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sunil Gupta</i>				29c. LICENSE NUMBER <b>D 33280</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 22, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. SUNIL GUPTA, JOHNSON HEIGHTS MEDICAL BLDG., CUMBERLAND, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>APR 25 1995</b>				32. REGISTRAR'S SIGNATURE <i>John A. Marshall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14542

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RALPH O. OWENS</b>			2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>20</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>0710</b> M
4. SOCIAL SECURITY NUMBER <b>217-10-2165</b>	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>74</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>8-14-1920</b>	8. BIRTHPLACE (State or Foreign Country) <b>Md.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>			9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>
RESIDENCE OF DECEDENT					
10a. STATE <b>Md.</b>	10b. COUNTY <b>Wicomico</b>	10c. CITY, TOWN OR LOCATION <b>Eden</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3748 Stockyard Road</b>		10f. ZIP CODE <b>21822</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII Army</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Maintenance</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Wicomico County Board of Education</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Willie Owens</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bertha Adkins Owens</b>		
19a. INFORMANT'S NAME (Type/Print) <b>June D. Owens</b>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3748 Stockyard Rd. Eden, Md. 21822</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Stephens Cemetery</b>		20c. LOCATION — City or Town, State <b>4-23 Delmar, De.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William M. Short</i>			22. NAME AND ADDRESS OF FACILITY <b>Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  a. <b>CONVULSANT ARTERY DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>RENAL FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>ACUTE MYOCARDITIS</b> DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate Interval Between Onset and Death  <b>yrs</b>  <b>10 yrs</b>  <b>DAYS</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edward Klope</i> M.D.			29c. LICENSE NUMBER <b>18053</b>	29d. DATE SIGNED (Month, Day, Year) <b>4-20-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Edward Klope 25 Medical Center Salisbury, Md. 21801</b>					
31. DATE FILED (Month, Day, Year) <b>APR 24 1995</b>		32. REGISTRAR'S SIGNATURE <i>John A. Wilson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14543

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GARY P OAKLEY</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>30</b> , 1995 YEAR		3. TIME OF DEATH <b>05:20</b> am	
4. SOCIAL SECURITY NUMBER <b>577-04-3526</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>31</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 2, 1964</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>CALVERT MEMORIAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>PRINCE FREDERICK, MD</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
RESIDENCE OF DECEDENT				9c. COUNTY OF DEATH <b>CALVERT</b>			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Calvert</b>		10c. CITY, TOWN OR LOCATION <b>Huntingtown</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3000 Holland Cliffs Road</b>				10f. ZIP CODE <b>20639</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Caucasian</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Heavy Equipment Operator</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Construction</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Reginald Phillip Oakley</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Agnes Miles</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary A. Oakley</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P. O. Box 24 Huntingtown, Maryland 20639</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Washington National Cemetery May 3, 1995</b>		20c. LOCATION — City or Town, State <b>Suitland, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acquired immune deficiency syndrome</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>3 years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Charles W. Bennett M.D.</b>				29c. LICENSE NUMBER <b>025156</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 30, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) Type/print <b>CHARLES W. BENNETT M.D. 11845 H.G. TRUEMAN RD. LUSBY, MD. 20657</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 02 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.




IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14544

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Mary Landon Ogden</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>30</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>8:45 a</b> M	
4. SOCIAL SECURITY NUMBER <b>212 48 4651</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>94</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 11, 1901</b>	
8a. FACILITY NAME (If not Institution, give street and number) <b>Calvert County Nursing Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Prince Frederick</b>		9c. COUNTY OF DEATH <b>Calvert</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Calvert</b>		10c. CITY, TOWN OR LOCATION <b>Prince Frederick</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>60 Main Street</b>				10f. ZIP CODE <b>20678</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>homemaker</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George W. Hance</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lydia Bowen</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Kenneth Ogden</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 96 Prince Frederick Maryland 20678</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Wesley Cemetery May 31, 1995</b>		20c. LOCATION — City or Town, State <b>Prince Frederick MD</b>		20d. DATE <b>May 31, 1995</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>OLD AGE.</b>							
a. DUE TO (OR AS A CONSEQUENCE OF): <b>A.S.H.D.</b>							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 2 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D 03077</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-30-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Issam F el-Damalouji, M.D. 135 West Dares Beacg Rd. Prince Frederick MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAY - 3 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14545

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHRISTOPHER NICHOLAS PHOTAKIS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 22, 1995</b>		3. TIME OF DEATH <b>3:15 A M</b>	
4. SOCIAL SECURITY NUMBER <b>054-05-4026</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 13 1912</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>FERNWOOD HOUSE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BETHESDA</b>		9c. COUNTY OF DEATH <b>MONT.</b>	
RESIDENCE OF DECEDENT							
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Washington, D. C.</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3001 Veazey Terrace N. W.</b>				10f. ZIP CODE <b>20008</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5 +</b> College (1-4 or 5+) <b>5 +</b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Dentist</b>		16a. KIND OF BUSINESS/INDUSTRY <b>Dentistry</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Nicholas Photakis</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Chariclis Papadam</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Catherine A. Photakis</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3001 Veazey Terr. N.W. Washington, D.C. 20008</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arlington National Cemetery 4/26</b>		20c. LOCATION — City or Town, State <b>Arlington VA</b>		20d. LOCATION — City or Town, State <b>VA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Vernon Simmons</i>				22. NAME AND ADDRESS OF FACILITY <b>Joseph Gawler's Sons</b> <b>5130 WI Ave. NW Washington, D.C. 20016</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory failure</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>Emphysema</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
d. <b>Acute Diverticulitis</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Calhoun</i>				29c. LICENSE NUMBER <b>D 31319</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 24, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>LORETO S. ALBIOL M.D. 8218 WISCONSIN AVE BETHESDA, MARYLAND 20814</b>							
31. DATE FILED (Month, Day, Year) <b>APR 27 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.







95 14546

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lucile T. Peterson				2. DATE OF DEATH MONTH DAY YEAR April 20, 1995		3. TIME OF DEATH 6:45 pm M	
4. SOCIAL SECURITY NUMBER 429-10-3695		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) October 2, 1916	
8. BIRTHPLACE (State or Foreign Country) Arkansas				9a. FACILITY NAME (If not institution, give street and number) Rockville Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Rockville	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Rockville				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 303 Adclare Road	
10f. ZIP CODE 20850				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 2 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) D.A. Tucker				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Mae Faulkner			
19a. INFORMANT'S NAME (Type/Print) Clark B. Nelson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1738 Lamont Street N.W. Washington, D.C. 20010			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fairmount Cemetery April 26, 1995		20c. LOCATION — City or Town, State Denver, Colorado	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00335				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Alzheimers DUE TO (OR AS A CONSEQUENCE OF): c. Emphysema DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death Weeks Years Years							PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Frauke Westphal M.D.				29c. LICENSE NUMBER 19785		29d. DATE SIGNED (Month, Day, Year) April 21, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Frauke Westphal M.D. 809 Veirs Mill Road #101 Rockville, Maryland 20851-1689							
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14547

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Mildred Clark Peters</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 18, 1995</b>		3. TIME OF DEATH <b>4:20 P M</b>	
4. SOCIAL SECURITY NUMBER <b>577-22-4505</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>August 9, 1912</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>		9c. COUNTY OF DEATH <b>Frederick</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Mt. Airy</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>5631 Catoctin Ridge Drive</b>				10f. ZIP CODE <b>21771</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Residence Manager</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Property Management</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Howard Clark</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Carrie Milstead</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Alice D. Savin</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1402 S.C. Terrace Lake Worth, Florida 33460</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory 4/22/95</b>		20c. LOCATION — City or Town, State <b>Alexandria, Virginia</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Anchew J. Cole</i>				22. NAME AND ADDRESS OF FACILITY <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acute Pulmonary Edema</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>10 minutes</b> <b>5 years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Allen J. Gilson</i>		29c. LICENSE NUMBER <b>D 26516</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 21 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Allen J. Gilson MD 1475 TANEY Ave Fred MD 21202</b>							
31. DATE FILED (Month, Day, Year) <b>APR 24 1995</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Amended #1 4/25/95 MRT Montgomery County 95 14548  
FOR STATE REGISTRAR  
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KATHLEEN MARGARET Margaret PANZONE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APR 20 1995</b>		3. TIME OF DEATH <b>6:29 A</b> M			
4. SOCIAL SECURITY NUMBER <b>579-28-6596</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 21, 1926</b>		8. BIRTHPLACE (State or Foreign Country) <b>Washington, D.C.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Holy Cross Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>			9c. COUNTY OF DEATH <b>Montgomery</b>		
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER <b>3811 Brightview Street</b>				10f. ZIP CODE <b>20902</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>				
17. FATHER'S NAME (First, Middle, Last) <b>John Joseph Broderick</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Ellen O'Connor</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Domenick Panzone, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3811 Brightview Street Silver Spring, Maryland 20902</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery 4/24/95 Silver Spring, Maryland</b>			20c. LOCATION — City or Town, State				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. RESPIRATORY FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. EMPHYSEMA</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. SMOKING</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Approximate Interval Between Onset and Death <b>3 DAYS</b> <b>4 YRS</b>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>BRONCHOGENIC CARCINOMA, RECURRENT; HYPERTENSION; BACK PAIN</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Steven T. Kariya MD</b>				29c. LICENSE NUMBER <b>D36252</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/20/95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>STEVEN T. KARIYA, MD, 11501 GEORGIA AVE #515 WHEATON MD 20902</b>									
31. DATE FILED (Month, Day, Year) <b>APR 25 1995</b>				32. REGISTRAR'S SIGNATURE 					



95 14549

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Louise Crane Patterson				2. DATE OF DEATH MONTH DAY YEAR April 21 1995		3. TIME OF DEATH 2:10 P M	
4. SOCIAL SECURITY NUMBER 455-05-7944		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 6, 1908	
8. BIRTHPLACE (State or Foreign Country) Tennessee		9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 13805 Old Columbia Pike		10f. ZIP CODE 20904	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor		16b. KIND OF BUSINESS/INDUSTRY Federal Government	
17. FATHER'S NAME (First, Middle, Last) Lenwood Crane				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian Green			
19a. INFORMANT'S NAME (Type/Print) Edward A. Raia				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13805 Old Columbia Pike, Silver Spring, MD 20904			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Summertown Cemetery 4/27/95		20c. LOCATION — City or Town, State Summertown, Tennessee	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Christopher Marshall</i>				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Sil. Spr. MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Neurogenic coma &amp; shock 48</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Massive Cerebral bleeding</i> b. <i>Hypertension</i> c. <i></i> d. <i></i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i></i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Oleg Shpak</i>				29c. LICENSE NUMBER 234860		29d. DATE SIGNED (Month, Day, Year) 4/21/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Oleg Shpak, M.D. 9470 Annapolis Road #210 Lanham, MD 20706							
31. DATE FILED (Month, Day, Year) APR 25 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14550

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ARTHUR PERRYMAN III</b>						2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 21, 1995</b>		3. TIME OF DEATH <b>11:25 P M</b>	
4. SOCIAL SECURITY NUMBER <b>211-58-0926</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>19</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>FEB. 13, 1976</b>		8. BIRTHPLACE (State or Foreign Country) <b>R.I.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>CHILDRENS INN</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>BETHESDA</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>PA.</b>		10b. COUNTY <b>MONROE</b>		10c. CITY, TOWN OR LOCATION <b>EAST STROUDSBURG</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>196 LACKAWANNA AVE.</b>				10f. ZIP CODE <b>18301</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>STUDENT</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SCHOOL</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>ARTHUR PERRYMAN JR.</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BLENDA MALIN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>BLENDA PERRYMAN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS ITEM #10</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>PROSPECT CEMETERY</b>		DATE <b>4/27</b>		20c. LOCATION — City or Town, State <b>EAST STROUDSBURG, PA.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.W. Chambers</i> M00091				22. NAME AND ADDRESS OF FACILITY <b>W. W. CHAMBERS CO., RIVERDALE, MD. 20737</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>cardiorespiratory arrest</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>diffuse pulmonary metastases - renal failure</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>relapsing rhabdomyosarcoma</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>metastatic rhabdomyosarcoma</i>								Approximate Interval Between Onset and Death  <b>3w</b> <b>3w</b> <b>1y</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Childrens' Inn</b>					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>4/21/95</b>		28b. TIME OF INJURY <b>11:25 P M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>H.U. Kontny, MD</i>						29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>4/22/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>H.U. Kontny, MD PB, NC 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892</b>									
31. DATE FILED (Month, Day, Year) <b>APR 25 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14551

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) NATALIA MARIE PINEDA				2. DATE OF DEATH MONTH DAY YEAR APRIL 19, 1995		3. TIME OF DEATH 3:30 A.M.	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS.		7. DATE OF BIRTH (Month, Day, Year) April 19, 1995	
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1714 Noyes Lane				10f. ZIP CODE 20910		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: Peruvian		14. RACE — American Indian, Black, White, etc. Specify: Hispanic/Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) None		16b. KIND OF BUSINESS/INDUSTRY Not Applicable			
17. FATHER'S NAME (First, Middle, Last) Rodolfo Pineda				18. MOTHER'S NAME (First, Middle, Maiden Surname) Tia Marie Gibson			
19a. INFORMANT'S NAME (Type/Print) Mr. Rodolfo Pineda				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1714 Noyes Lane, Silver Spring, Maryland 20910			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 4/22/95		20c. LOCATION — City or Town, State Silver Spring, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, Maryland 20904			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. EXTREME PREMATURITY/22 wks Gestational Age DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. PROBABLE INCOMPETENT CERVIX DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D36543		29d. DATE SIGNED (Month, Day, Year) APRIL 21, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHRISTOPHER HULTZEN, MD 9901 MEDICAL CENTER DR., ROCKVILLE, MD 20850-3395							
31. DATE FILED (Month, Day, Year) APR 26 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14552

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Mary H Pollack</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>22</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>01 50 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>578-28-2804</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>APRIL 22, 1916</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SHADY GROVE HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ROCKVILLE</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>SILVER SPRING</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>13301 HATHAWAY DRIVE</b>				10f. ZIP CODE <b>20906</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (13-16 or 17+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SECRETARY</b>		16b. KIND OF BUSINESS/INDUSTRY <b>FEDERAL GOVERNMENT</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ISAAC COHEN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ETHEL FRIEDMAN</b>			
19a. INFORMANT'S NAME (Type Print) <b>JAY POLLACK (SON)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13301 HATHAWAY DRIVE—SILVER SPRING, MD. 20906</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>OHIV SHOLOM CONG. CEM. 4/25</b>		20c. LOCATION — City or Town, State <b>WASHINGTON, D.C.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE—ROCKVILLE, MD. 20852</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Hyperventilation-Hypoxemia</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>End Stage Chronic Obstructive Pulmonary Disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Gastrointestinal Bleeding</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Diabetes Type II</b>							Approximate Interval Between Onset and Death hours years days years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>S. Neulfar MD</i>				29c. LICENSE NUMBER <b>31391 D</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 23 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>19261 Montgomery Village Ave - Gaithersburg MD 20879</b>							
31. DATE FILED (Month, Day, Year) <b>APR 26 1995</b>				32. REGISTRAR'S SIGNATURE <i>Jubia Dawson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14553

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Dorothy Press</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 22, 1995</b>		3. TIME OF DEATH <b>6:15 P M</b>	
4. SOCIAL SECURITY NUMBER <b>060-09-6014</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 25, 1911</b>	
8. BIRTHPLACE (State or Foreign Country) <b>New York</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Potomac Valley Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Rockville</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>1235 Potomac Valley Road</b>				10f. ZIP CODE <b>20850</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Clerk / Secretary</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Clerk / Secretary</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Life Insurance Company</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Unavailable</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Unavailable</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Lawrence L. Bell</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11921 Rockville Pike, #300, Rockville, MD 20852</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		DATE <b>4-23</b>		20c. LOCATION — City or Town, State <b>Beltsville, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Eileen H. Rapp</b>				22. NAME AND ADDRESS OF FACILITY <b>Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lung Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Lung Cancer</b> b. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> Approximate Interval Between Onset and Death <b>3 years</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Marvin Wadler, M.D.</b>					
29c. LICENSE NUMBER <b>D23068</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 23, 1995</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Marvin Wadler, M. D., 8218 Wisconsin Avenue, Bethesda, MD 20814</b>							
31. DATE FILED (Month, Day, Year) <b>APR 26 1995</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14554

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOSEPH F. PATANELLA</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>22</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>6:45PM</b> M	
4. SOCIAL SECURITY NUMBER <b>196-07-8574</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 18, 1912</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Illinois</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Spellman Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Cheverly</b>	
9c. COUNTY OF DEATH <b>Prince Georges</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince Georges</b>	
10c. CITY, TOWN OR LOCATION <b>Lanham</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>6805 Trexler Road</b>	
10f. ZIP CODE <b>20706</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Steelworker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Steel Mill</b>	
17. FATHER'S NAME (First, Middle, Last) <b>James Patanella</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Pauline Calabianca</b>			
19a. INFORMANT'S NAME (Type/Print) <b>James Patanella</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>920 Sunset Valley Drive, Sykesville, Maryland 21784</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Druid Ridge Cemetery 4/26</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Anthony S. Dime</b>				22. NAME AND ADDRESS OF FACILITY <b>Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RESPIRATORY FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>ENCEPHALOPATHY</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>ASPIRATION PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>H/O - RENAL INSUFFICIENCY</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b></b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>ATHEROSCLEROSIS - EXTENSIVE; D.M.; HE - WGS - DNR.</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>S. Rao MD</b>		29c. LICENSE NUMBER <b>D-34525</b>	
29d. DATE SIGNED (Month, Day, Year) <b>04-23-95</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>S. J. Rao, MD - 4000 Mitchellville Road; #220; Bowie - 20716-MD</b>			
31. DATE FILED (Month, Day, Year) <b>APR 27 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 14555

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Marie Frances PUTMAN				2. DATE OF DEATH MONTH April 30, DAY 1995 YEAR		3. TIME OF DEATH 7:15 AM	
4. SOCIAL SECURITY NUMBER 214-36-1523		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 10, 1920	
9a. FACILITY NAME (If not institution, give street and number) 1190 Avondale Court				9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1190 Avondale Court				10f. ZIP CODE 21702		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 9 College (1-4 or 5+) 9		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Jesse NUSBAUM				18. MOTHER'S NAME (First, Middle, Maiden Surname) Janie KENNA			
19a. INFORMANT'S NAME (Type/Print) Mrs. Ella M. Curry				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1190 Avondale Court, Frederick, Maryland 21702			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resthaven Memorial Gardens, May 3, 1995		20c. LOCATION — City or Town, State Frederick, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Rich E. Gray M00255				22. NAME AND ADDRESS OF FACILITY Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ADENOCARCINOMA OF THE COLON DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. SEQUENTIALLY LIST CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Bryan M. O'Connor, MD				29c. LICENSE NUMBER D31861		29d. DATE SIGNED (Month, Day, Year) May 1, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BRYAN M. O'CONNOR 531 W. SEVENTH ST. FREDERICK MD 21701							
31. DATE FILED (Month, Day, Year) MAY 01 1995				32. REGISTRAR'S SIGNATURE Julia Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Hubert Lee Perry</b>				2. DATE OF DEATH MONTH <b>04</b> DAY <b>03</b> YEAR <b>95</b>		3. TIME OF DEATH <b>2:51 AM</b>	
4. SOCIAL SECURITY NUMBER <b>214-30-7291</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAY 25, 1932</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>LAUREL REGIONAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>LAUREL</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGES</b>	
10a. STATE <b>NA</b>				10b. COUNTY <b>NA</b>		10c. CITY, TOWN OR LOCATION <b>WASHINGTON, D.C.</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>610 3RD STREET, S.E. #7</b>			
10f. ZIP CODE <b>20003</b>				10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SUPERVISOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>CONSTRUCTION</b>	
17. FATHER'S NAME (First, Middle, Last) <b>FRANCIS PERRY</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>JOANNA ALSTON</b>			
19a. INFORMANT'S NAME (Print) <b>DELORES CLEMENS (DAUGHTER)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4902 KEY COURT, SUITLAND, MARYLAND 20746</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>LINCOLN MEMORIAL CEMETERY 4/8</b>		20c. LOCATION — City or Town, State <b>SUITLAND, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Alex S. Pope</b> M859				22. NAME AND ADDRESS OF FACILITY <b>ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE, FORESTVILLE, MD 20747</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Pulmonary Embolus, main pulmonary artery and extension to both lungs.</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>D36792</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/13/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ANEES AHASAN, MD 7610 CARROLL AVE. SUITE 380 TAKOMA PARK, MD 20912</b>							
31. DATE FILED (Month, Day, Year) <b>APR 06 1995</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14557

Amended #1, 4/12/95, J W, Montgomery County

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>PATRICIA PARENT TAYLOR PARENT</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>07</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>10:06 am</b>	
4. SOCIAL SECURITY NUMBER <b>217-42-3838</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>49</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 14, 1945</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Massachusetts</b>				9a. FACILITY NAME (If not institution, give street and number) <b>JOHNS HOPKINS HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Rockville</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1525 Baylor Avenue</b>	
10f. ZIP CODE <b>20850</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Computer Programmer</b>	
16b. KIND OF BUSINESS/INDUSTRY <b>Geico Insurance Co.</b>		17. FATHER'S NAME (First, Middle, Last) <b>Harold Stanley Taylor</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret Loretta Daley</b>		19a. INFORMANT'S NAME (Type/Print) <b>Michael S. Parent</b>	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1525 Baylor Avenue, Rockville, Maryland 20850</b>		20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery 4/11/95</b>		20c. LOCATION — City or Town, State <b>Silver Spring, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>DeVol Funeral Home</b> <b>10 East Deer Park Drive</b> <b>Gaithersburg, MD 20877</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> a. <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Chemotherapy induced immunosuppression</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>M3 Acute Myelogenous Leukemia</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Polycythemia Vera</b>		Approximate Interval Between Onset and Death <b>12 hours</b> <b>40 days</b> <b>2 months</b> <b>21 years</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Derek M Fine M.D.</b>		29c. LICENSE NUMBER <b>M6241</b>	
29d. DATE SIGNED (Month, Day, Year) <b>04/07/95</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DEREK M FINE JOHNS HOPKINS HOSPITAL</b>					
31. DATE FILED (Month, Day, Year) <b>APR 12 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14558

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <i>Willis Purcell Sr.</i>			2. DATE OF DEATH MONTH DAY YEAR <i>April 24, 1995</i>		3. TIME OF DEATH <i>1:45 A</i>
4. SOCIAL SECURITY NUMBER <i>238-44-5460</i>	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>61</i> YRS.	7. DATE OF BIRTH (Month, Day, Year) <i>7-12-33</i>	8. BIRTHPLACE (State or Foreign Country) <i>North Carolina</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Prince Georges Hospital</i>			9b. CITY, TOWN OR LOCATION OF DEATH <i>Cheverly</i>		9c. COUNTY OF DEATH <i>P.G.</i>
10a. STATE <i>md.</i>			10b. COUNTY <i>P.G.</i>		10c. CITY, TOWN OR LOCATION <i>Capitol Heights</i>
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			10e. STREET AND NUMBER <i>#20 Tunic Ave.</i>		
10f. ZIP CODE <i>20743</i>			10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>1953-1955</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (14 or 5+) <i>College</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Counselor</i>	
16b. KIND OF BUSINESS/INDUSTRY <i>Government</i>		17. FATHER'S NAME (First, Middle, Last) <i>Willie Purcell</i>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Sarah Galbreth</i>	
19. INFORMANT'S NAME (Type/Print) <i>Rosella Purcell</i>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>#20 Tunic Ave. Cap. Hgts. Md 20743</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Harmony Cemetery 4/29/95</i>		20c. LOCATION — City or Town, State <i>Landover, Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Prince Edwards</i>		22. NAME AND ADDRESS OF FACILITY <i>Hodges &amp; Edwards 3910 Silver Hill Rd. Suit. Md.</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Diabetic hyperosmolar syndrome, cerebral vascular disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Asthma</i>					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i>		29c. LICENSE NUMBER <i>2212.30</i>		29d. DATE SIGNED (Month, Day, Year) <i>April 26, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augusto P. Rodriguez MD 5709 Reypum Ct. Cp Spr - Md 20748</i>					
31. DATE FILED (Month, Day, Year) <i>MAY 08 1995</i>		31. REGISTRAR'S SIGNATURE <i>John D. Carroll</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Amended #4, 10C, 4/28/95, N.H.S., Allegany Co.

95 14559

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES MARSHALL PUGH</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>25</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>0420 A M</b>			
4. SOCIAL SECURITY NUMBER <b>220-16-5591</b>		5. SEX <b>1 M 2 F</b>		8. AGE (In yrs. last birthday) <b>84 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>May 13, 1910</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Sacred Heart Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>			9c. COUNTY OF DEATH <b>Allegany</b>		
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>1 Baltimore Street Cumberland</b>			10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>		
10e. STREET AND NUMBER <b>1 Baltimore Street</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <b>3 Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b> Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12th</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) <b>Sales Representative</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Cemetery</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Wade H. Pugh, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary N. Hood</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Catherine E. Yocum</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt.3, Box 44 Rawlings, Maryland 21557</b>					
20a. METHOD OF DISPOSITION <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Potomac Mem. Gardens Apr. 28, 1995 Keyser, West Virginia</b>		20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Handwritten Signature</i>				22. NAME AND ADDRESS OF FACILITY <b>Markwood McKenzie Funeral Home 111 S. Mineral Street, Keyser, WV 26726</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> a. <b>ACUTE RESPIRATORY FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>PULMONARY EMBOLISM</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> Approximate Interval Between Onset and Death <b>5 days</b> <b>5 days</b> <b>2 WEEKS</b>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CONGESTIVE HEART FAILURE</b>									
24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>									
26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>									
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>		28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Handwritten Signature</i>				29c. LICENSE NUMBER <b>23334-D</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 25th 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DINESH B. SHARMA, M.D. 225 JOHNSON HEIGHTS, CUMBERLAND, MD 21502</b>									
31. DATE FILED (Month, Day, Year) <b>APR 27 1995</b>		32. REGISTRAR'S SIGNATURE <i>Handwritten Signature</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

My dear Mr. [illegible]

Yours very truly  
[illegible]

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ALDEN C. PLUMMER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 24, 1995</b>		3. TIME OF DEATH <b>5:55 A M</b>	
4. SOCIAL SECURITY NUMBER <b>212-24-0376</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sep 6, 1927</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD</b>				9a. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9b. COUNTY OF DEATH <b>Allegany</b>	
10. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>							
11. RESIDENCE OF DECEDENT							
11a. STATE <b>WV</b>		11b. COUNTY <b>Mineral</b>		11c. CITY, TOWN OR LOCATION <b>Ridgeley</b>		11d. INSIDE CITY LIMITS? <b>1 X YES 2 NO</b>	
12. STREET AND NUMBER <b>Route 1 Box 125-L</b>				13. ZIP CODE <b>26753</b>		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. MARITAL STATUS <b>1 X Never Married 2 Married 3 Widowed 4 Divorced</b>		16. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 X YES 2 NO</b> IF YES, GIVE WAR OR DATES <b>WW II</b>		17. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 X NO</b> Specify:		18. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
19. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b> <b>College (1-4 or 5+) College</b>		20. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Retired Supervisor</b>		21. KIND OF BUSINESS/INDUSTRY <b>Textile</b>			
22. FATHER'S NAME (First, Middle, Last) <b>Emery Plummer</b>				23. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Edna (DeVore)</b>			
24. INFORMANT'S NAME (Type/Print) <b>Virginia S. Plummer</b>				25. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Route 1 Box 125-L; Ridgeley, WV 26753</b>			
26. METHOD OF DISPOSITION <b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		27. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rocky Gap Veterans Cem. 04/26</b>		28. DATE <b>04/26</b>		29. LOCATION — City or Town, State <b>Flintstone, MD</b>	
30. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i>				31. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>			
32. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Respiratory Failure</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> a. <b>Acute Respiratory Failure</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Chronic Obstructive Pulmonary Disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. <b>Approximate Interval Between Onset and Death</b> <b>70 days</b> <b>Unknown</b>							
33. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES X NO UNCERTAIN</b>							
34. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 X NO</b>		35. PLACE OF DEATH (Check only one) <b>HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA</b> <b>OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)</b>					
36. MANNER OF DEATH <b>1 X Natural 2 Accident 3 Suicide 4 Homicide</b> <b>5 Pending Investigation 6 Could not be determined</b>		37. DATE OF INJURY (Month, Day, Year)		38. TIME OF INJURY <b>M</b>		39. INJURY AT WORK? <b>1 YES 2 NO</b>	
40. DESCRIBE HOW INJURY OCCURRED				41. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
42. CERTIFIER (Check only one) <b>1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
43. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. S. Gupta</i>				44. LICENSE NUMBER <b>D 33280</b>		45. DATE SIGNED (Month, Day, Year) <b>April 24, 1995</b>	
46. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. S. Gupta Memorial Hospital Medical Bldg. Cumberland, MD 21502</b>							
47. DATE FILED (Month, Day, Year) <b>APR 26 1995</b>		48. REGISTRAR'S SIGNATURE <i>[Signature]</i>					



95 14561

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY VIRGINIA PAUL				2. DATE OF DEATH MONTH DAY YEAR April 24, 1995		3. TIME OF DEATH 5:30 A M	
4. SOCIAL SECURITY NUMBER 213-40-3556		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 53 YRS.		7. DATE OF BIRTH (Month, Day, Year) MARCH 30 1942	
9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY	
10a. STATE MARYLAND				10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION CUMBERLAND	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER P.O. BOX #106 OLD COUNTRY CLUB ROAD				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CROWN CORK & SEAL CO.		16b. KIND OF BUSINESS/INDUSTRY MANUF. LABORER			
17. FATHER'S NAME (First, Middle, Last) MARLIN L. DOLAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) HELEN V. GOSS			
19a. INFORMANT'S NAME (Type/Print) RONALD E. PAUL JR.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX #715 STEPHENS CITY, VIRGINIA 22655			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SUNSET CEMETERY APRIL 27 1995		20c. LOCATION — City or Town, State CUMBERLAND MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dale L. Merritt				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ADVANCED NON SMALL CARCINOMA OF LUNG DUE TO (OR AS A CONSEQUENCE OF): b. HYPERCOAGULABILITY SYNDROME DUE TO (OR AS A CONSEQUENCE OF): c. SITUATIONAL DEPRESSION DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 2 YEARS 1 1/2 YEARS 2 YEARS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Q. Zaman MD		29c. LICENSE NUMBER D 23371		29d. DATE SIGNED (Month, Day, Year) April 25, 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Q. Zaman, Johnson Heights Medical Bldg., Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) APR 26 1995				32. REGISTRAR'S SIGNATURE			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

4

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14562

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MABEL</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>21</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>10:15 P M</b>											
4. SOCIAL SECURITY NUMBER <b>237-38-7947</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-20-1917</b>		8. BIRTHPLACE (State or Foreign Country) <b>N. Carolina</b>											
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>				9c. COUNTY OF DEATH											
RESIDENCE OF DECEDENT																			
10a. STATE <b>Delaware</b>		10b. COUNTY <b>Sussex</b>		10c. CITY, TOWN OR LOCATION <b>Georgetown</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO											
10e. STREET AND NUMBER <b>500 Margaret St.</b>				10f. ZIP CODE <b>19947</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>													
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>												
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Factory Worker</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Poultry</b>												
17. FATHER'S NAME (First, Middle, Last) <b>Frank T. Jeffers</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Addie Staten</b>															
19a. INFORMANT'S NAME (Type/Print) <b>Addie Phillip</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 343, Georgetown, DE. 19947</b>															
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cem. St. John Bap. Church 4-95</b>			20c. LOCATION — City or Town, State <b>Millsboro, DE.</b>												
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Clarence E. Young</i>				22. NAME AND ADDRESS OF FACILITY <b>Young's Funeral Homes 309 North St., Milford, DE. 19963</b>															
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Laryngeal Cancer</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <table border="0"> <tr> <td>a. <b>Liver Failure</b></td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td>Approximate Interval Between Onset and Death <b>1 month</b></td> </tr> <tr> <td>b. <b>Renal Failure</b></td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td><b>3 weeks</b></td> </tr> <tr> <td>c. <b>malnutrition</b></td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td><b>3 weeks</b></td> </tr> <tr> <td>d. <b></b></td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td><b>1 month</b></td> </tr> </table>								a. <b>Liver Failure</b>	DUE TO (OR AS A CONSEQUENCE OF):	Approximate Interval Between Onset and Death <b>1 month</b>	b. <b>Renal Failure</b>	DUE TO (OR AS A CONSEQUENCE OF):	<b>3 weeks</b>	c. <b>malnutrition</b>	DUE TO (OR AS A CONSEQUENCE OF):	<b>3 weeks</b>	d. <b></b>	DUE TO (OR AS A CONSEQUENCE OF):	<b>1 month</b>
a. <b>Liver Failure</b>	DUE TO (OR AS A CONSEQUENCE OF):	Approximate Interval Between Onset and Death <b>1 month</b>																	
b. <b>Renal Failure</b>	DUE TO (OR AS A CONSEQUENCE OF):	<b>3 weeks</b>																	
c. <b>malnutrition</b>	DUE TO (OR AS A CONSEQUENCE OF):	<b>3 weeks</b>																	
d. <b></b>	DUE TO (OR AS A CONSEQUENCE OF):	<b>1 month</b>																	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED											
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)															
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Toni Sublett MD</i>				29c. LICENSE NUMBER <b>M6156</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/21/95</b>													
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>TONI SUBLETT, MD 600 N. Wolfe Tower 110 BALTIMORE, MD 21205</b>																			
31. DATE FILED (Month, Day, Year) <b>APR 25 1995</b>				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>															

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

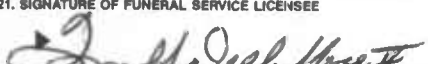
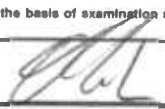
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JACK</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>13</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>3:30 P M</b>			
4. SOCIAL SECURITY NUMBER <b>244-38-9642</b>		5. SEX <b>M</b> <input checked="" type="checkbox"/> <b>F</b> <input type="checkbox"/>		6. AGE (In yrs. last birthday) <b>66</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 7, 1929</b>		8. BIRTHPLACE (State or Foreign Country) <b>N. CAROLINA</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>3318 HOLLINS FERRY ROAD</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>N/A</b>				9c. COUNTY OF DEATH <b>BALTIMORE</b>			
10a. STATE <b>MD.</b>		10b. COUNTY <b>ANN ARUNDEL</b>		10c. CITY, TOWN OR LOCATION <b>N/A</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>3318 Hollins Ferry Rd</b>				10f. ZIP CODE <b>21227</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1948</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO - Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MAINTENANCE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>FOOD SERVICE</b>							
17. FATHER'S NAME (First, Middle, Last) <b>WILLARD PHILLIPS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MATTIE COOK</b>							
19a. INFORMANT'S NAME (Type/Print) <b>DOUG WILLIAMS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1 BOYMANS CT. BALTO. 21206 MD.</b>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>OAKHAWN CEMETERY</b>		DATE <b>4/19</b>		20c. LOCATION — City or Town, State <b>BALTO MD.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>DELLA NOCE &amp; SONS FUNERAL HOME</b> <b>322 S. HIGH ST. BALTO. 21202 MD.</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SEIZURE DISORDER</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
26. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		27. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>USED CAR DEALERSHIP</b>									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 14, 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DAVID R. FOWLER M.D. 111 Penn Street, Baltimore, Maryland 21201</b>											
31. DATE FILED (Month, Day, Year) <b>MAY 09 1995</b>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14564

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ERNEST GEORGE PORTER</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>19</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>10:40 A</b>	
4. SOCIAL SECURITY NUMBER <b>218-09-5725</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>07/25/18</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Wesleyan Health Care Center</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Denton</b>		8c. COUNTY OF DEATH <b>Caroline</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Caroline</b>		10c. CITY, TOWN OR LOCATION <b>Federalsburg</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>606 Old Denton Road</b>				10f. ZIP CODE <b>21632</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) _____		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Truck Driver</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Trucking</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George Porter</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Eliza A. Trice</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Theresa L. Porter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>606 Old Denton Rd., Federalsburg, MD 21632</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Concord Cemetery</b>		DATE <b>4-23</b>		20c. LOCATION — City or Town, State <b>Federalsburg, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Michael F. Eskow</b>				22. NAME AND ADDRESS OF FACILITY <b>Frampton-Hawkins-Eskow Funeral Home PO Box 43, Federalsburg, MD 21632</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Gastric Carcinoma</b> Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. _____							Approximate Interval Between Onset and Death <b>3/95</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>D32036</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/23/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Gay Sporne 2108 Red Apple Place Choke, MD 21619</b>							
31. DATE FILED (Month, Day, Year) <b>APR 26 '95</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14565

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>William Roger Proctor</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 21, 1995</i>		3. TIME OF DEATH HOURS MINUTES <i>10:40 P</i>	
4. SOCIAL SECURITY NUMBER <i>220-26-2653</i>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. <i>66</i>		7. DATE OF BIRTH (Month, Day, Year) <i>Feb. 26, 1929</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>				9a. FACILITY NAME (If not institution, give street and number) <i>9711 Temple Hills Rd</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Clinton</i>	
9c. COUNTY OF DEATH <i>Prince George</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Prince George</i>	
10c. CITY, TOWN OR LOCATION <i>Clinton</i>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>9711 Temple Hills Road</i>	
10f. ZIP CODE <i>20735</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>American Indian</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>Inspector</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Inspector</i>		16b. KIND OF BUSINESS/INDUSTRY <i>WSSC</i>	
17. FATHER'S NAME (First, Middle, Last) <i>William L Proctor</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Elizabeth Harley</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Ruth Proctor</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9711 Temple Hills Rd, Clinton MD 20735</i>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Resurrection April 25, 1995 Clinton MD</i>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lloyd P. Papp</i>				22. NAME AND ADDRESS OF FACILITY <i>Adams Funeral Home, Aquasco MD 20608</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arteriosclerotic cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <i>1</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i>				29c. LICENSE NUMBER <i>D21230</i>		29d. DATE SIGNED (Month, Day, Year) <i>April 22, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augusta P. Rodriguez MD, 5009 Rayburn Ct. C, Sp. Md 20748</i>							
31. DATE FILED (Month, Day, Year) <i>APR 28 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

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95 14566

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Glenna Frances Rota				2. DATE OF DEATH MONTH DAY YEAR April 22, 1995		3. TIME OF DEATH 3:35 P. M.	
4. SOCIAL SECURITY NUMBER 223-18-3701		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1919 December 30, Virginia	
9a. FACILITY NAME (If not institution, give street and number) Randolph Hills Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Wheaton		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4504 Bennion Road				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY Federal Government			
17. FATHER'S NAME (First, Middle, Last) Robert G. Moore				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marion Knowles			
19a. INFORMANT'S NAME (Type/Print) Carlo J. Rota				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4504 Bennion Road Silver Spring, Maryland 20906			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 4/26/95		20c. LOCATION — City or Town, State Silver Spring, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Ventricular Tachycardia</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Congestive Heart Failure</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Chronic Ischemic Heart Disease</u> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death Minutes 3 Days 10 Years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Insulin dependent diabetes mellitus</u>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Mark M. Chung, M.D.</u>				29c. LICENSE NUMBER <u>A21615</u>		29d. DATE SIGNED (Month, Day, Year) <u>4-24-95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Mark M. Chung, M.D. 3929 Ferrara Dr Wheaton Maryland 20906</u>							
31. DATE FILED (Month, Day, Year) <u>APR 26 1995</u>				32. REGISTRAR'S SIGNATURE <u>John Davis</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

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95 14567

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Ellen Rekstad				2. DATE OF DEATH MONTH DAY YEAR APRIL 20 95		3. TIME OF DEATH 5:25am		
4. SOCIAL SECURITY NUMBER 356-24-7443		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 25, 1932		
8. BIRTHPLACE (State or Foreign Country) Illinois				9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Bethesda		
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery		
10c. CITY, TOWN OR LOCATION Bethesda				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 7358 Westlake Terrace		
10f. ZIP CODE 20817				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Realtor		16b. KIND OF BUSINESS/INDUSTRY Real Estate		
17. FATHER'S NAME (First, Middle, Last) Sedwin Rekstad				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mabel Pauline Olson				
19a. INFORMANT'S NAME (Type/Print) Dorothy Louise Phillips				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36W604 Oak Ridge Lane St. Charles, Illinois 60174				
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 4/24/95 Alexandria, Virginia		20c. LOCATION — City or Town, State		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Christopher Madburn</i>				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cerebrovascular Accident</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Subarachnoid + Right Temporal Lobe Intra- Cerebral hemorrhage</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST d. _____ DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>None</i>							Approximate Interval Between Onset and Death 7 hours	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donna Rink MD</i>				29c. LICENSE NUMBER D28135		29d. DATE SIGNED (Month, Day, Year) 4/20/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONNA RINKS MD 11510 OLD GEORGETOWN RD, ROCKVILLE, MD 20852								
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Amended #7, 4/25/95 MRT Montgomery County 95 14568

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Francis Joseph Roxburghe				2. DATE OF DEATH MONTH DAY YEAR April 21, 1995		3. TIME OF DEATH 4:43 P M			
4. SOCIAL SECURITY NUMBER 579-34-1591		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1929 August 8,		8. BIRTHPLACE (State or Foreign Country) Washington, D.C.	
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring				9c. COUNTY OF DEATH Montgomery	
10a. STATE Pennsylvania		10b. COUNTY Huntingdon		10c. CITY, TOWN OR LOCATION Huntingdon				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER Star Route Box 157				10f. ZIP CODE 16652		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Assistant Treasurer Branch Manager		16b. KIND OF BUSINESS/INDUSTRY Banking					
17. FATHER'S NAME (First, Middle, Last) James Roxburghe				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Rhodes					
19a. INFORMANT'S NAME (Type/Print) Norma L. Roxburghe				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Star Route Box 157 Huntingdon, Pennsylvania 16652					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery 4/25/95		20c. LOCATION — City or Town, State Suitland, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): b. Generalized Arteriosclerotic Disease cardiovascular DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 20 20									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus									
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Wesley B. Mason M.D.				29c. LICENSE NUMBER D 22235		29d. DATE SIGNED (Month, Day, Year) 4/21/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Wesley B. Mason, 10810 Connecticut Ave, Kensington, Md., 20895									
31. DATE FILED (Month, Day, Year) APR 25 1995				32. REGISTRAR'S SIGNATURE Julia Davidson Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14569

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary L. Richardson				2. DATE OF DEATH MONTH DAY YEAR April 21, 1995		3. TIME OF DEATH 3:15 A M	
4. SOCIAL SECURITY NUMBER 578-46-5271		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 14, 1921	
9a. FACILITY NAME (If not institution, give street and number) 8020 Park Lane				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Bethesda		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8020 Park Lane				10f. ZIP CODE 20814		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Administrator		16b. KIND OF BUSINESS/INDUSTRY Consolidated Natural Gas			
17. FATHER'S NAME (First, Middle, Last) Not available				18. MOTHER'S NAME (First, Middle, Maiden Surname) Not available			
19a. INFORMANT'S NAME (Type/Print) John L. Richardson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13013 Minetta Lane, Bowie, Maryland 20715			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. April 24, 1995		20c. LOCATION — City or Town, State Bethesda, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michelle G. Kutta</i> M00348				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Breast Cancer DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 7 Months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Thomas A. Bensinger MD</i>		29c. LICENSE NUMBER D08754		29d. DATE SIGNED (Month, Day, Year) April 21, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED COUSE OF DEATH (ITEM 27) (Type, Print) Thomas A. Bensinger, M.D., 7525 Greenway Center Drive, #205, Greenbelt, MD 20770							
31. DATE FILED (Month, Day, Year) APR 26 1995		32. REGISTRAR'S SIGNATURE <i>Johanna Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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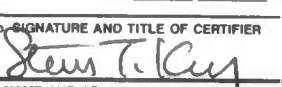
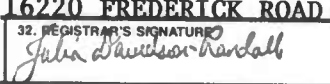




95 14570

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LUCILLE RIIBNER</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>23</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>0100 A M</b>	
4. SOCIAL SECURITY NUMBER <b>579-48-5554</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>59</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7. DATE OF BIRTH (Month, Day, Year) <b>MAY 3, 1935</b>				8. BIRTHPLACE (State or Foreign Country) <b>WASHINGTON, DC</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ROCKVILLE</b>				9c. COUNTY OF DEATH <b>MARYLAND</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>ROCKVILLE</b>			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>2525 LINDLEY TERRACE</b>		10f. ZIP CODE <b>20850</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>OFFICE MANAGER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>ELECTRONICS</b>			
17. FATHER'S NAME (First, Middle, Last) <b>FRED MARKOWITZ</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANN KUSHNER</b>					
19a. INFORMANT'S NAME (Type/Print) <b>HERMAN RIIBNER (HUSBAND)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2525 LINDLEY TERRACE, ROCKVILLE, MD 20850</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>KING DAVID</b>		DATE <b>4-25</b>		20c. LOCATION — City or Town, State <b>FALLS CHURCH, VIRGINIA</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RESPIRATORY FAILURE</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>COMA</b> b. <b>SEIZURE</b> c. <b>BRAIN METASTASIS, PRIOR</b> d. <b>LUNG CANCER, EMPHYSEMA</b>								Approximate Interval Between Onset and Death <b>3 DAYS</b> <b>1 WEEK</b> <b>1 WEEK</b> <b>4 MONTHS</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>LUNG CANCER, EMPHYSEMA</b>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO								DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D36252</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 24, 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>STEVEN T. KARIYA, 16220 FREDERICK ROAD #213 GAITHERSBURG, MARYLAND 20877</b>									
31. DATE FILED (Month, Day, Year) <b>APR 26 1995</b>				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

10

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 14571

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jno D. Randall				2. DATE OF DEATH MONTH DAY YEAR April 27, 1995		3. TIME OF DEATH 2:55AM M	
4. SOCIAL SECURITY NUMBER 284-12-1191		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 19, 1921	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania		9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Potomac		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8924 Wooden Bridge Road				10f. ZIP CODE 20854		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Librarian		16b. KIND OF BUSINESS/INDUSTRY Medical	
17. FATHER'S NAME (First, Middle, Last) not available				18. MOTHER'S NAME (First, Middle, Maiden Surname) not available			
19a. INFORMANT'S NAME (Type/Print) Robert A. Kohler				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8924 Wooden Bridge Road, Potomac, Maryland 20854			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. April 28, 1995		20c. LOCATION — City or Town, State Bethesda, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barbara J. McMullen Lawrence</i> M00831				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>sepsis</i> DUE TO (OR AS A CONSEQUENCE OF): <i>dehydration and uremia</i> DUE TO (OR AS A CONSEQUENCE OF): <i>chronic obstructive pulmonary disease</i> DUE TO (OR AS A CONSEQUENCE OF): <i>organic brain syndrome</i> Approximate Interval Between Onset and Death <i>10 days</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Walter E. Gooch MD</i>				29c. LICENSE NUMBER D01120		29d. DATE SIGNED (Month, Day, Year) April 27, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) WALTER E. GOOCH MD 2309 SHOREFIELD ROAD WHEATON MD 20902							
31. DATE FILED (Month, Day, Year) APR 28 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

6+1




TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Amended #10b, #10e 4/26/95 MRT Montgomery County 95 14572  
FOR STATE REGISTRAR  
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH  
REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROSA S. REDFEARN</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>21</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>8:20p</b>			
4. SOCIAL SECURITY NUMBER <b>579-76-1446</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>38</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>August 30, 1956</b>		8. BIRTHPLACE (State or Foreign Country) <b>D. C.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SOUTHERN MARYLAND HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CLINTON</b>			9c. COUNTY OF DEATH <b>PRINCE GEORGE'S</b>		
10a. STATE <b>Md.</b>		10b. COUNTY <b>Prince George</b>		10c. CITY, TOWN OR LOCATION <b>Capital Heights</b>			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER <b>1403 Dunbar A Oaks Drive</b>				10f. ZIP CODE <b>20743</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Letter Carrier</b>			16b. KIND OF BUSINESS/INDUSTRY <b>U. S. Postal Service</b>		
17. FATHER'S NAME (First, Middle, Last) <b>John King</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rosa Williams</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Gerald Redfearn</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1403 Dunbar Oaks Dr., Capital Hqts., Md. 20743</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Harmony Memorial Park</b>		DATE <b>4/29</b>		20c. LOCATION — City or Town, State <b>Landover, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>R. N. Horton Co. Morticians, Inc. 600 Kennedy Street, N. W.</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Right Basal ganglion bleed</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Malignant hypertension</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>  Approximate Interval Between Onset and Death <b>9 hours</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>4.21.95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29, Type, Print) <b>8201 Corporate Drive Suite 620 Landover Md 20785</b>									
31. DATE FILED (Month, Day, Year) <b>APR 26 1995</b>				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14573

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Maria Locadia RAMIREZ				2. DATE OF DEATH MONTH: April, DAY: 30, YEAR: 1995				3. TIME OF DEATH 1:00 AM			
4. SOCIAL SECURITY NUMBER 463-66-2288		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 65 YRS.	7. DATE OF BIRTH (Month, Day, Year) Dec. 9, 1929		8. BIRTHPLACE (State or Foreign Country) Texas					
9a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Frederick			9c. COUNTY OF DEATH Frederick				
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				
10e. STREET AND NUMBER 1016 E Stork Street				10f. ZIP CODE 21702		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: Mexican			14. RACE — American Indian, Black, White, etc. Specify: Hispanic				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1		15b. DECEDEENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home							
17. FATHER'S NAME (First, Middle, Last) Secundino RAMIREZ				18. MOTHER'S NAME (First, Middle, Maiden Surname) Carmen MALACARA							
19a. INFORMANT'S NAME (Type/Print) Adan Gonzales				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1016 E Stork Street, Frederick, Md. 21702							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg Crematory May 1, 1995		20c. LOCATION — City or Town, State Smithsburg, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Richard E. Gray M00255				22. NAME AND ADDRESS OF FACILITY Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sacral Decubitus DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death 1 month			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peripheral Vascular Disease Diabetes								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Allen J. Gilson				29c. LICENSE NUMBER D 26516		29d. DATE SIGNED (Month, Day, Year) May 1 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Allen J. Gilson MD 1475 Taney Avenue, Frederick, Maryland 21702											
31. DATE FILED (Month, Day, Year) MAY 01 1995				32. REGISTRAR'S SIGNATURE John Davidson Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14574

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (Last, First, Middle) <b>ANNIE E. ROGERS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 12 1995</b>				3. TIME OF DEATH HOURS MINUTES <b>2:35 A M</b>					
4. SOCIAL SECURITY NUMBER <b>579-34-1298</b>				5. SEX <b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>92</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11/5/1902</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Fairhaven Retirement Center</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Sykesville</b>				9c. COUNTY OF DEATH <b>Carroll</b>			
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Prince Georges</b>				10c. CITY, TOWN OR LOCATION <b>Riverdale</b>					
10d. INSIDE CITY LIMITS? <b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>6009 Taylor Avenue</b>				10f. ZIP CODE <b>20737</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married <b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Caucasian</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>4</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Teacher</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Elementary School</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Robert Nelson Rampley</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Annie Laurie Bevard</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Mary E. Preston</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4503 Norrisville Rd. White Hall, Md. 21161</b>							
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>Bethel Cemetery 4/14</b>				20c. LOCATION — City or Town, State <b>Madonna, Maryland</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>						22. NAME AND ADDRESS OF FACILITY <b>Kurtz Funeral Home Jarrettsville, Maryland</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause for each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b> DUE TO (OR AS A CONSEQUENCE OF): <b>DEHYDRATION</b> Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <b>DEMENTIA</b> DUE TO (OR AS A CONSEQUENCE OF):										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MYOCARDIAL INFARCTION</b> <b>HIP FRACTURE</b>										24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide <b>6</b> <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFY (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD		29c. LICENSE NUMBER <b>D22220</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/12/95</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) <b>Ellis Mez MD 1645 Liberty Rd. Eldersburg, MD. 21744</b>													
31. DATE FILED (Month, Day, Year) <b>APR 20 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

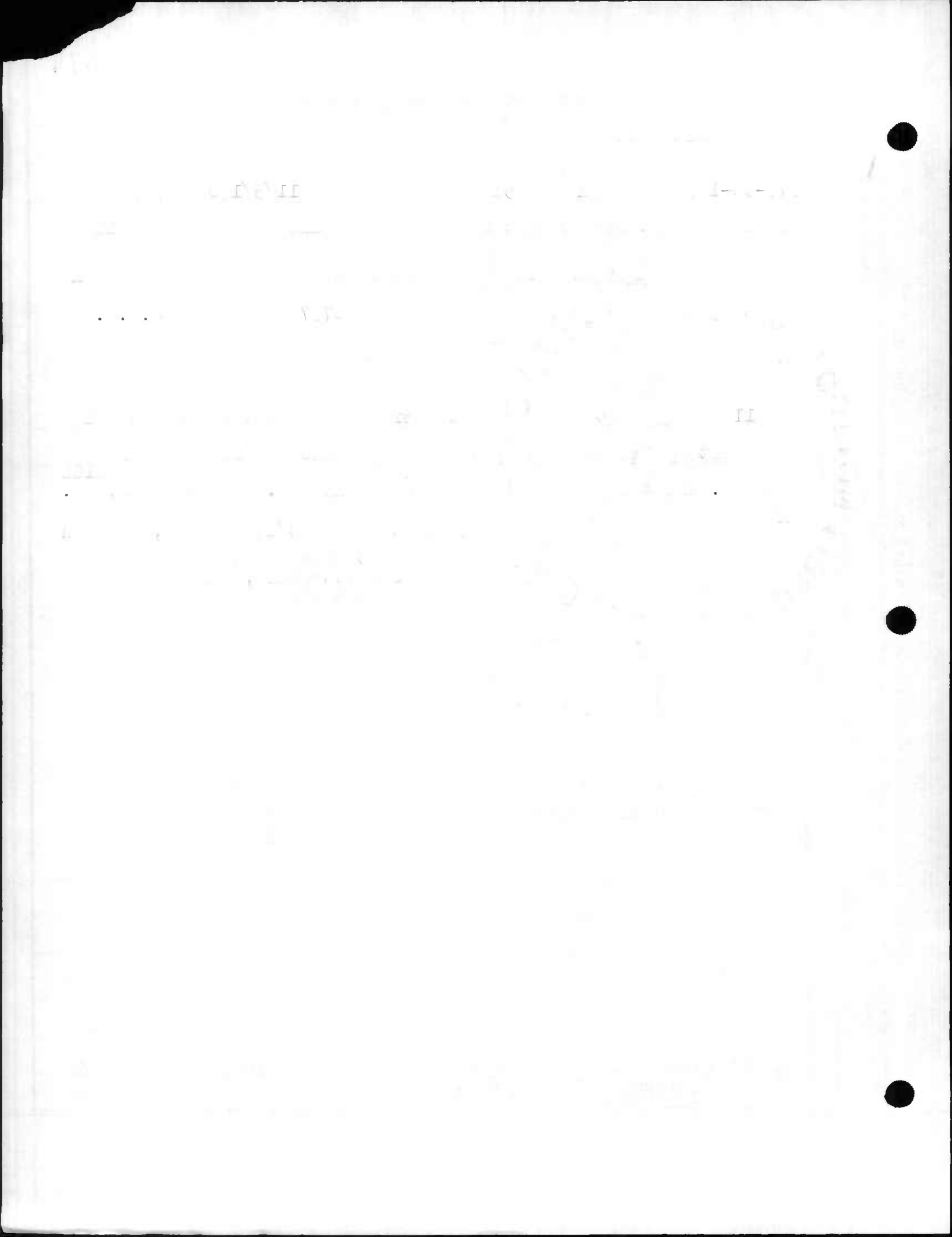
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14575

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HENRY FRANK RESCH</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>4</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>06:55 AM</b>	
4. SOCIAL SECURITY NUMBER <b>219-05-4739</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 11, 1915</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>St. Agnes Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Howard</b>		10c. CITY, TOWN OR LOCATION <b>Elkridge</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>6660 Montgomery Road</b>			
10f. ZIP CODE <b>21227</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Brick Mason</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Construction</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Francis Jacob Resch</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dorothy Louise Kramer</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Isabel A. Resch</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6660 Montgomery Road Elkridge Maryland 21227</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Crestlawn Memorial Gardens 5-6</b>		20c. LOCATION — City or Town, State <b>Marriottsville, MD</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Stanley M. Lowner</b>				22. NAME AND ADDRESS OF FACILITY <b>HARRY WITZKE Funeral Home 7120 Old Columbia Pike Ellicott City</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF): <b>Metastatic Cancer lungs (Primary unknown)</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD; Deep Vein Thrombosis; Left Femoral Artery occlusion</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Paul W. [Signature] MD Resident</b>				29c. LICENSE NUMBER <b>D-44789</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 4, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dep. Med. ST. AGNES HOSPITAL 900 CATON AVE BALTIMORE MD 21229</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 05 1995</b>				32. REGISTRAR'S SIGNATURE <b>John [Signature] Hardell</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14576

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Hazel Charles Reed</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 6 1995</i>		3. TIME OF DEATH 1900 M	
4. SOCIAL SECURITY NUMBER <i>222-20-3007A</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>86</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>June 12, 1908</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Smyrna, DE</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Med-Point Nursing Home</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Elkton</i>	
9c. COUNTY OF DEATH <i>Cecil</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Cecil</i>	
10c. CITY, TOWN OR LOCATION <i>Elkton</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>One Price Drive</i>	
10f. ZIP CODE <i>21921</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>8</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>building/maint.</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Delmarva</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Alfred Reed</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Sallie Richard</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Charles Reed (son)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>P.O. Box 9682 Newark, DE 19714-9682</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Gracelawn Memorial Park</i>		20c. LOCATION — City or Town, State <i>New Castle, De.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael J. Scollally</i>				22. NAME AND ADDRESS OF FACILITY <i>McCrery Funeral Homes, Inc. 3924 Concord Pike Wilm., De. 19808</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Food Aspiration</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Bilateral Pneumonia</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sheelmoan S. Sachdev</i>				29c. LICENSE NUMBER <i>D23322</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/10/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>118 North St, Elkton Md. 21921 Sheelmoan S. SACHDEV, M.D.</i>							
31. DATE FILED (Month, Day, Year) <i>APR 10 1995</i>				32. REGISTRAR'S SIGNATURE <i>J. A. Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14577

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RASCOE baby boy, Quincey Rascoe</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>30</b> YEAR <b>95</b>		3. TIME OF DEATH <b>4:38 A</b> M	
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>04/30/95</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Prince Georges Hospital Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cheverly</b>		9c. COUNTY OF DEATH <b>Prince Georges</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince Georges</b>		10c. CITY, TOWN OR LOCATION <b>Cheverly</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>15 Cheverly Circle</b>				10f. ZIP CODE <b>20785</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b>none</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>none</b>		16b. KIND OF BUSINESS/INDUSTRY <b>none</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Robert E. Rascoe</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Robinette Rascoe</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mother</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15 Cheverly Circle, Cheverly, Maryland 20785</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>by hospital</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>▶</b>				22. NAME AND ADDRESS OF FACILITY			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Extreme prematurity (21 weeks gestation)</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Premature labor</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>4/30/95</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>G. Marwah MD</b>				29c. LICENSE NUMBER <b>D-43822</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/30/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>G. MARWAH MD, NICU, PG COUNTY HOSP., CHEVERLY (MD.)</b>							
31. DATE FILED (Month, Day, Year) <b>4/30 MAY 11 1995</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CRAIGE R. ROSNICK</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>30</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>03:40 A M</b>	
4. SOCIAL SECURITY NUMBER <b>189-38-8086</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>47</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAY 28, 1947</b>	
8. BIRTHPLACE (State or Foreign Country) <b>PENNSYLVANIA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>MONTGOMERY GENERAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>OLNEY</b>	
9c. COUNTY OF DEATH <b>MONTGOMERY</b>				10a. STATE <b>MARYLAND</b>			
10b. COUNTY <b>MONTGOMERY</b>				10c. CITY, TOWN OR LOCATION <b>OLNEY</b>			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>4012 CHERRY VALLEY DRIVE</b>			
10f. ZIP CODE <b>20832</b>				10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1979</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CONTRACT NEGOTIATOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. GOVERNMENT</b>	
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM ROSNICK</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MABEL CARPENTER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JANICE M. ROSNICK</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4012 CHERRY VALLEY DRIVE OLNEY, MARYLAND 20832</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>METROPOLITAN CREMATORY 5/1/95</b>		20c. LOCATION — City or Town, State <b>ALEXANDRIA, VIRGINIA</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Muriel H. Barber</i>	
22. NAME AND ADDRESS OF FACILITY <b>MURIEL H. BARBER FUNERAL HOME 20882 P.O. BOX 5038 LAYTONSVILLE, MARYLAND</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>hepato-renal syndrome</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>cirrhosis of liver</b> DUE TO (OR AS A CONSEQUENCE OF): <b>alcoholism</b> DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>1 week</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edward P. Tashman MD</i>		29c. LICENSE NUMBER <b>123459</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 30, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Edward P. Tashman 18111 Prince Philip Dr. Arlington MD 20832</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 08 1995</b>		32. REGISTRAR'S SIGNATURE <i>John A. Hurd</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.




IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14579

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GENEVIEVE ANNE RUPPERT</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>25</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>0848</b> M	
4. SOCIAL SECURITY NUMBER <b>213 22 3819</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>SEPT 2 1907</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ALLEGANY</b>		10c. CITY, TOWN OR LOCATION <b>CUMBERLAND, MARYLAND</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>CHRISTIE ROAD 10301</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>4</b>		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSE KEEPER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOUSE KEEPER</b>			
17. FATHER'S NAME (First, Middle, Last) <b>CHARLES DECKER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ROSE MARGARET STOVER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>TIMOTHY STEIN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1925 OTAY LAKE ROAD #12, CHULA VISTA, CALIF. 91913</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SUNSET CEMETERY APRIL 28 1995</b>		DATE <b>APRIL 28 1995</b>		20c. LOCATION — City or Town, State <b>CUMBERLAND MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>e. HYPERTENSIVE ARTERIOSCLEROTIC VASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>30 YEARS</b> <b>b. HYPERTENSION</b> DUE TO (OR AS A CONSEQUENCE OF): <b>40 YEARS</b> <b>c. HYPERTENSIVE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>50 YEARS</b> <b>d.</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSIVE</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D17565</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/26/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. ANTHONY BOLLINO 955 FREDERICK ST. CUMBERLAND, MARYLAND</b>							
31. DATE FILED (Month, Day, Year) <b>APR 27 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14580

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Donald Lewis Reid				2. DATE OF DEATH MONTH DAY YEAR April 26, 1995		3. TIME OF DEATH 6:44 P M	
4. SOCIAL SECURITY NUMBER 215-20-2139		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept 25, 1926	
9a. FACILITY NAME (If not institution, give street and number) Dorchester General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cambridge		9c. COUNTY OF DEATH Dorchester	
RESIDENCE OF DECEDENT				10c. CITY, TOWN OR LOCATION Cambridge		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10a. STATE Maryland		10b. COUNTY Dorchester		10e. STREET AND NUMBER 1205 Hambrooks Blvd.		10f. ZIP CODE 21613	
10g. CITIZEN OF WHAT COUNTRY? US		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Office Manager		16b. KIND OF BUSINESS/INDUSTRY Auto Body Repair Shop			
17. FATHER'S NAME (First, Middle, Last) Johnston Frederick Reid				18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy Brown			
19a. INFORMANT'S NAME (Type/Print) Betty Lou Reid				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1205 Hambrooks Blvd. Cambridge, Md. 21613			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) East New Market Cemetery 4/30		20c. LOCATION — City or Town, State East New Market, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St. Cambridge, Maryland 21613			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cerebrovascular accident</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death 3 days
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Atherosclerotic Cardiovascular disease; Ventricular aneurysm with mural thrombus; Hypertension</u> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 035749		29d. DATE SIGNED (Month, Day, Year) 4/26/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David G. O'Leary MD 503 Datchmans Lane Easton MD 21601							
31. DATE FILED (Month, Day, Year) APR 28 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



HERMAN RUARK

95 14581

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) HERMAN ALBERT RUARK				2. DATE OF DEATH MONTH DAY YEAR April 19 1995		3. TIME OF DEATH 12:30 A M	
4. SOCIAL SECURITY NUMBER 214-32-2087		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) September 8, 1908	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) SALISBURY NURSING & Rehab. CENTER		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY, MD.	
9c. COUNTY OF DEATH WICOMICO				10a. STATE Maryland		10b. COUNTY Wicomico	
10c. CITY, TOWN OR LOCATION Salisbury				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 111 Civic Ave.	
10f. ZIP CODE 21801				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Hatcheryman		16b. KIND OF BUSINESS/INDUSTRY Poultry	
17. FATHER'S NAME (First, Middle, Last) Elijah Purnell Ruark				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Hestor Adkins			
19a. INFORMANT'S NAME (Type/Print) Anna Marie Hill				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Civic Ave., Salisbury, MD 21801			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bethel U.M. Church Cemetery 4/22		20c. LOCATION — City or Town, State Walston Switch, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CONGESTIVE HEART FAILURE</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death YEARS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>COPD</u> <u>Dementia</u> <u>COLON CANCER</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER D-39813		29d. DATE SIGNED (Month, Day, Year) 4/19/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD., 21801							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14582

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Ervin Edward Routzan</u>				2. DATE OF DEATH MONTH <u>April</u> DAY <u>21</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>4:22 A.M.</u>	
4. SOCIAL SECURITY NUMBER <u>212-24-5852</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>66</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>09-05-1928</u>	
8. FACILITY NAME (If not institution, give street and number) <u>Harford Memorial Hospital</u>				9. CITY, TOWN OR LOCATION OF DEATH <u>Havre de Grace</u>		10. COUNTY OF DEATH <u>Harford</u>	
11. RESIDENCE OF DECEDENT				12. STATE <u>MD</u>		13. COUNTY <u>Harford</u>	
14. STREET AND NUMBER <u>729 Old Philadelphia Road</u>				15. ZIP CODE <u>21001</u>		16. CITY, TOWN OR LOCATION <u>Aberdeen</u>	
17. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				18. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>Korean</u>		19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>GED</u> College (1-4 or 5+) <u>College</u>				21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Carpenter</u>		22. KIND OF BUSINESS/INDUSTRY <u>Construction</u>	
23. FATHER'S NAME (First, Middle, Last) <u>Edward Routzan</u>				24. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Esther Harris</u>			
25. INFORMANT'S NAME (Type/Print) <u>Mrs. Doris M. Routzan</u>				26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>729 Old Philadelphia Road, Aberdeen, MD 21001</u>			
27. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				28. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>R. A. Ferris &amp; Co., Inc</u>		29. DATE <u>4/25</u>	
30. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>William S. Smith</u>				31. NAME AND ADDRESS OF FACILITY <u>Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Myocardial infarction</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Coronary artery disease</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Aorto-ilio-femoral arteriosclerotic stenosis (lyra)</u> DUE TO (OR AS A CONSEQUENCE OF): d. _____ SEQUENTIALLY LIST CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>S/P Aorto-bifemoral aortic graft</u> <u>S/P Left femoro-popliteal graft</u> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
24. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		25. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
26. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		27. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
28. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		29. DATE OF INJURY (Month, Day, Year)		30. TIME OF INJURY <u>M</u>		31. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
32. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				33. DESCRIBE HOW INJURY OCCURRED			
34. LOCATION (Street and Number or Rural Route Number, City or Town, State)				35. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
36. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
37. SIGNATURE AND TITLE OF CERTIFIER <u>Richard J. Coughlin MD DEPT. MEDICAL EXAMINER</u>				38. LICENSE NUMBER <u>D-14544</u>		39. DATE SIGNED (Month, Day, Year) <u>April 21 1995</u>	
40. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>IAN D. SOMERVILLE 400 LEWIS ST. HAVRE DE GRACE MD 21078</u>							
41. DATE FILED (Month, Day, Year) <u>APR 25 1995</u>				42. REGISTRAR'S SIGNATURE <u>Alia Anderson-Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


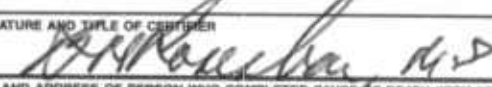

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTER

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO

1. DECEDENT'S NAME (First, Middle, Last) <b>Worthey Edwin Strite</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 20 1995</b>				3. TIME OF DEATH <b>2:30 P M</b>							
4. SOCIAL SECURITY NUMBER <b>578-09-0848</b>		6. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>April 30, 1917</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>10610 Hayes Avenue</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>						9c. COUNTY OF DEATH <b>Montgomery</b>			
RESIDENCE OF DECEDENT															
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>				10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>10610 Hayes Avenue</b>						10f. ZIP CODE <b>20902</b>			10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>						
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>World War II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 6+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Electronics Technician</b>				16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Government</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Worthey E. Strite, Sr.</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Frances Ullrich</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Doris K. Strite</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10610 Hayes Ave., Silver Spring, MD 20902</b>											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Md. Veterans Cemetery 4/25/95</b>				20c. LOCATION — City or Town, State <b>Cheltenham, MD</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr.MD 20901</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Carcinoma of Lung</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.												Approximate interval Between Onset and Death <b>2 years</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Heart Disease</b> <b>Diabetes Mellitus</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER 								29c. LICENSE NUMBER <b>D 09834</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 21, 1995</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Barry Rosenbaum, M.D. 3720 Farragut Avenue Kensington, MD 20895</b>															
31. DATE FILED (Month, Day, Year) <b>APR 24 1995</b>				32. REGISTRAR'S SIGNATURE 											

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate and filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

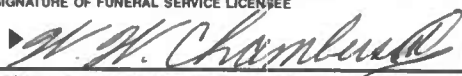

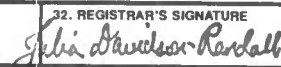
**TO BE COMPLETED BY FUNERAL DIRECTOR**



95 14584

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

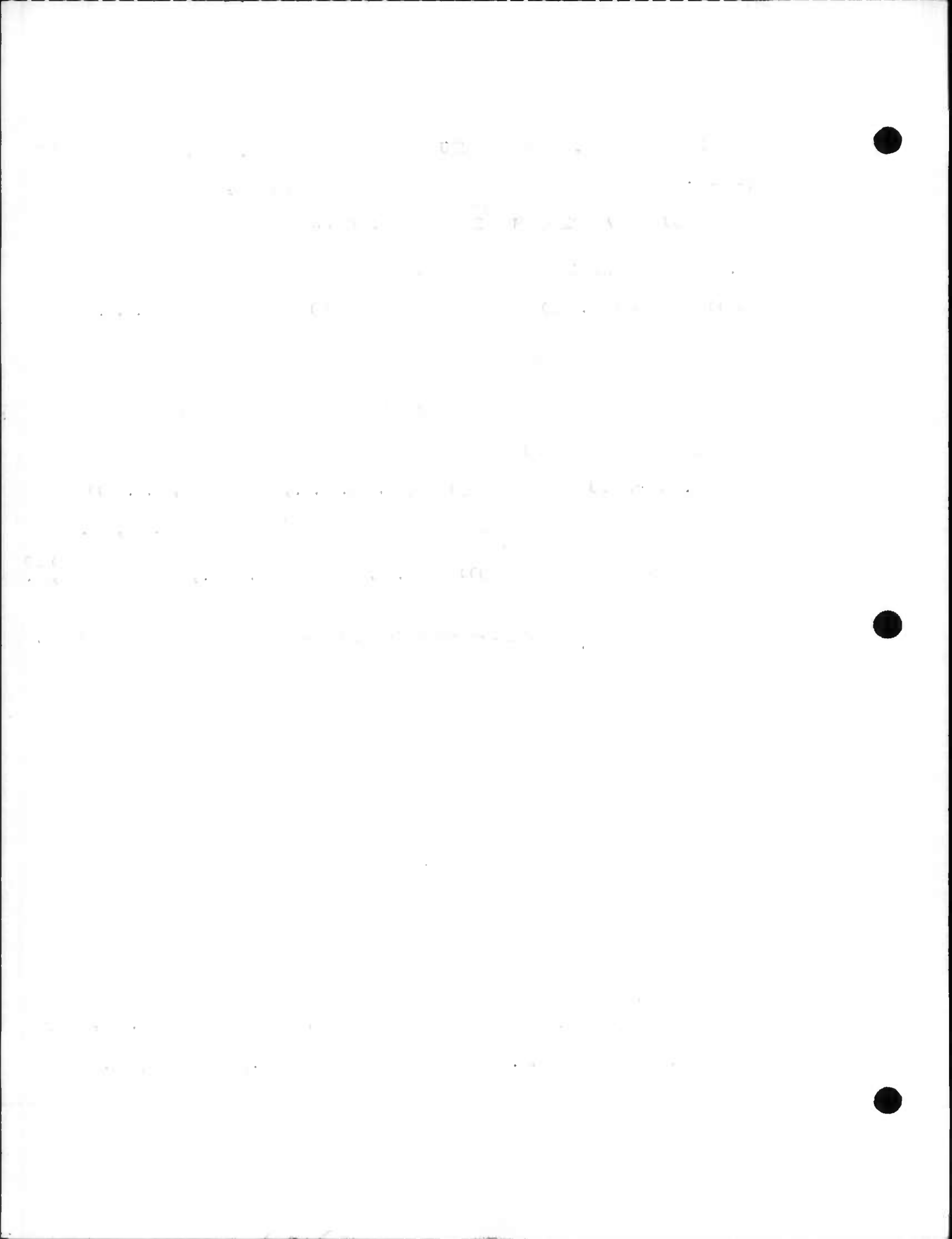
1. DECEDENT'S NAME (First, Middle, Last) <b>RICHARD A. SERVATIUS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APR. 22, 1995</b>		3. TIME OF DEATH <b>10:15A</b>	
4. SOCIAL SECURITY NUMBER <b>127-18-1342</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>66</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JUNE 1, 1928</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SHADY GROVE ADVENTIST CENTER NURSING</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ROCKVILLE</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD.</b>		10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>BETHESDA</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>10600 WEYMOUTH ST. #104</b>				10f. ZIP CODE <b>20814</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>KOREAN</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ADVERTISER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>ADVERTISING</b>	
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM SERVATIUS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNA MALONE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MARK W. SERVATIUS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4830 43rd. ST. N.W., WASHINGTON, D.C. 20016</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CHAMBERS CREMATORY</b>		DATE <b>4/25</b>		20c. LOCATION — City or Town, State <b>RIVERDALE, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>MO0091</b>				22. NAME AND ADDRESS OF FACILITY <b>W. W. CHAMBERS CO. INC., SILVER SPRING, MD. 20910</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>EXTENSIVE SMALL CELL LUNG CANCER</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <b>9 MOS.</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>MD.</b>				29c. LICENSE NUMBER <b>D37236</b>		29d. DATE SIGNED (Month, Day, Year) <b>APR. 24, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>CAROLYN B. HENDRICKS M.D. 9707 MEDICAL CENTER DR., ROCKVILLE, MD.</b>							
31. DATE FILED (Month, Day, Year) <b>APR 25 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

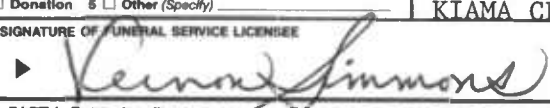

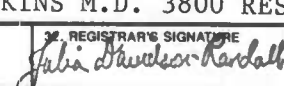
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14585

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>BRUCE JAMES SMITH</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 22, 1995</b>		3. TIME OF DEATH HOURS MINUTES P M <b>2:25 P M</b>	
4. SOCIAL SECURITY NUMBER <b>224 11 5758</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>53</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT. 21, 1941</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>10020 NEW LONDON DRIVE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>POTOMAC</b>		9c. COUNTY OF DEATH <b>MONT.</b>	
RESIDENCE OF DECEASED							
10a. STATE <b>MD</b>		10b. COUNTY <b>MONT.</b>		10c. CITY, TOWN OR LOCATION <b>POTOMAC</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>10020 NEW LONDON DRIVE</b>				10f. ZIP CODE <b>20854</b>		10g. CITIZEN OF WHAT COUNTRY? <b>Australia</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Economist, Deputy Dir.</b>		16b. KIND OF BUSINESS/INDUSTRY <b>International Monetary Fund</b>			
17. FATHER'S NAME (First, Middle, Last) <b>BASIL ALBERT SMITH</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ALICE WHITTLE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ANNE VANWYLUCK SMITH</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10020 NEW LONDON DR. POTOMAC, MARYLAND 20854</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>KIAMA CEMETERY</b>		20c. DATE <b>4/28/95</b>		20d. LOCATION — City or Town, State <b>NEW SOUTH WALES, AUST</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>JOS GAWLERS SONS INC. 5130 WISC. AVE NW WASHINGTON, D.C. 20016</b>			
23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>MALIGNANT MELANOMA</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>1 YEAR</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>19757-DC.</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/24/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MICHAEL J. HAWKINS M.D. 3800 RESERVOIR RD #P415 WASHINGTON, D.C. 20007</b>							
31. DATE FILED (Month, Day, Year) <b>APR 25 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14586

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ruth Smith				2. DATE OF DEATH MONTH DAY YEAR April 22 1995		3. TIME OF DEATH 10:35 P M	
4. SOCIAL SECURITY NUMBER 148-10-7672		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) May 26, 1918	
9a. FACILITY NAME (If not institution, give street and number) 15540 Prince Frederick Way				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 15540 Prince Frederick Way				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) George Schaefer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lella Guth			
19a. INFORMANT'S NAME (Type/Print) William Powley				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15513 Penny Royal Lane, Rockville, Maryland 20853			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery 5/1		20c. LOCATION — City or Town, State Arlington, Virginia		20d. LOCATION — City or Town, State Hines-Rinaldi Funeral Home	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY 11800 New Hampshire Avenue Silver Spring, Maryland 20904			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARCINOMA OF LUNG</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 4 months							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Emphysema</u>							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D.				29c. LICENSE NUMBER D 26540		29d. DATE SIGNED (Month, Day, Year) APRIL 24 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Carl L. Schaefer 16220 Frodoide Rd. Gaithersburg MD							
31. DATE FILED (Month, Day, Year) APR 26 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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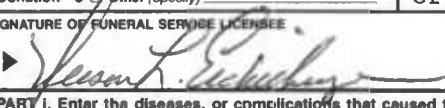

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14587

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Rosa Sancilio</b>				2. DATE OF DEATH MONTH DAY YEAR <b>04 20 1995</b>		3. TIME OF DEATH <b>5:25 P M</b>	
4. SOCIAL SECURITY NUMBER <b>073-26-8759</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 23, 1906</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Villa Rosa Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Mitchellville</b>		9c. COUNTY OF DEATH <b>Prince Georges</b>	
10a. STATE <b>Florida</b>				10b. COUNTY <b>Broward</b>		10c. CITY, TOWN OR LOCATION <b>Hollywood</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>320 S. Surf Road</b>			
10f. ZIP CODE <b>33019</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Francis Aloise</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Letetia Pasquale</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Lawrence Sancilio</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>940 Willowloaf Way, Rockville, Maryland 20854</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Greenwood Cemetery</b>		DATE <b>4/22</b>		20c. LOCATION — City or Town, State <b>Brooklyn, New York</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Hines-Rinaldi Funeral Home</b> <b>11800 New Hampshire Avenue</b> <b>Silver Spring, Maryland 20904</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Aspiration Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Septicemia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Neurogenic Dysphagia</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Chronic Obstructive Pulmonary Disease</b> <b>History of Hypertension</b>							Approximate Interval Between Onset and Death <b>4/14/95</b> <b>4/19/95</b> <b>2/95</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Obstructive Pulmonary Disease</b> <b>History of Hypertension</b>							24a. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Rakesh Anand, MD</b>		29c. LICENSE NUMBER <b>MD 20108</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/20/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>14300 GALLANT FOX LN #222 BOWIE, MD 20715</b>							
31. DATE FILED (Month, Day, Year) <b>APR 26 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 14588

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>James L. Sayles</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 25, 1995</b>		3. TIME OF DEATH <b>2:15 A M</b>	
4. SOCIAL SECURITY NUMBER <b>469-32-6932</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>60</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 25, 1934</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>2511 Parker Avenue</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Wheaton</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Wheaton</b>	
10d. INSIDE CITY LIMITS? <b>1 YES 2 X NO</b>							
10e. STREET AND NUMBER <b>2511 Parker Avenue</b>				10f. ZIP CODE <b>20902</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <b>1 Never Married 2 X Married 3 Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 X YES 2 NO</b> IF YES, GIVE WAR OR DATES <b>1953-1957</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 X NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (8-12) 4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Manager</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Social Security Adm.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Loren Lyle Sayles</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Gertrude Margaret Rustad</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Margaret R. Talbot</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10</b>			
20a. METHOD OF DISPOSITION <b>1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		20c. LOCATION — City or Town, State <b>4-25 Beltsville, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ellen H. Rapp</b>				22. NAME AND ADDRESS OF FACILITY <b>Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Metastatic pancreatic cancer</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval between Onset and Death <b>12 months</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pancytopenia</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 X NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 X Residence 6 Other (Specify)</b>					
27. MANNER OF DEATH <b>1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <b>1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Deena J. Shapiro MD</b>				29c. LICENSE NUMBER <b>D35336</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 25, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Deena J. Shapiro, M.D.</b>				<b>10810 Connecticut Avenue Kensington, MD 20895</b>			
31. DATE FILED (Month, Day, Year) <b>APR 26 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 14589

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Irma Rose Sullivan				2. DATE OF DEATH MONTH DAY YEAR April 25, 1995		3. TIME OF DEATH 10:05 P M	
4. SOCIAL SECURITY NUMBER 726-16-0204		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 13, 1910	
8. BIRTHPLACE (State or Foreign Country) Washington, D.C.				9a. FACILITY NAME (If not institution, give street and number) Greenbelt Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Greenbelt	
9c. COUNTY OF DEATH Prince George's				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 10702 Glenhaven Drive	
10f. ZIP CODE 20902				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Frank John Nesline				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hannah Marie Langbein			
19a. INFORMANT'S NAME (Type/Print) Richard Clement Sullivan, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10702 Glenhaven Drive Silver Spring, Maryland 20902			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 4/28/95 Silver Spring, Maryland		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Timothy A. Campbell</i>				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic Heart Disease DUE TO (OR AS A CONSEQUENCE OF): b. Congestive Heart Disease DUE TO (OR AS A CONSEQUENCE OF): c. Atrial Fibrillation DUE TO (OR AS A CONSEQUENCE OF): d. Neurogenic Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 3 months 3 months 2 years 3 months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Infected Decubitus Ulcer Dehydration DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Rakesh Arora, M.D.</i>				29c. LICENSE NUMBER D20108		29d. DATE SIGNED (Month, Day, Year) 4/26/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Rakesh Arora, M.D. 14300 Gallant Fox Lane Bowie, Maryland 20715							
31. DATE FILED (Month, Day, Year) APR 28 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

1. DECEDENT'S NAME (First, Middle, Last) <b>HARRIET B. SINES</b>						2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 30 95</b>		3. TIME OF DEATH <b>1;42 P M</b>					
4. SOCIAL SECURITY NUMBER <b>220-16-0233</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 7, 1917</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Frederick Memorial Hospital</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>						9c. COUNTY OF DEATH <b>Frederick</b>	
RESIDENCE OF DECEDENT													
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>				10c. CITY, TOWN OR LOCATION <b>Frederick</b>						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5703 Mount Laurel Place</b>						10f. ZIP CODE <b>21702</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>- -</b>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Seamstress</b>				15b. KIND OF BUSINESS/INDUSTRY <b>Clothing Manufacturer</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Clayton Lenhart</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Effie E. White</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Kenneth Sines</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5703 Mount Laurel PL./Frederick, Md. 21702</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Resthaven Memorial Gardens 5-3 Frederick, Maryland</b>				20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY <b>Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, Md. 21702</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. intracerebral Bleed</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____												Approximate Interval Between Onset and Death <b>14 hrs</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Breast Cancer</b>													
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER <b>D22101</b>				29d. DATE SIGNED (Month, Day, Year) <b>4/30/95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Lloyd Harrison 1425 Long Ave, Frederick md 21701</b>													
31. DATE FILED (Month, Day, Year) <b>MAY 03 1995</b>				32. REGISTRAR'S SIGNATURE 									



95 14591

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ERIC STEVENS</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>14</b> YEAR <b>95</b>		3. TIME OF DEATH <b>6:25 PM</b>	
4. SOCIAL SECURITY NUMBER <b>212-92-3547</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>32</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MARCH 12 1963</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>ANNE ARUNDEL MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ANNAPOLIS</b>		9c. COUNTY OF DEATH <b>ANNE ARUNDEL</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ANNE ARUNDEL</b>		10c. CITY, TOWN OR LOCATION <b>ANNAPOLIS</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1155 MADISON ST. APT. A 4</b>				10f. ZIP CODE <b>21403</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>CARPENTER</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CARPENTER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>JIM BLOUIN CO.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>HOWARD STEVENS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MABEL LUCILLE SIMPSON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>HOWARD STEVENS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14 GILMER STREET ANNAPOLIS, MD. 21401</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ANNAPOLIS MEM. GARDENS 4/21/95</b>		20c. LOCATION — City or Town, State <b>ANNAPOLIS, MD. 21401</b>		20d. DATE <b>4/21/95</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Larry H. Reese</b>				22. NAME AND ADDRESS OF FACILITY <b>REESE &amp; SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia - Bacterial</b> DUE TO (OR AS A CONSEQUENCE OF): <b>AIDS</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Hepatitis 2° Alcohol + Hepatitis-C</b> DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>3 wks</b> <b>3 yrs ±</b> <b>1 yr</b>							PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alcoholism -</b> <b>Spl splenectomy</b> <b>Anemia</b> <b>SIDPH</b>
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Joseph M. Friend</b>				29c. LICENSE NUMBER <b>D17965</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/14/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Joseph Friend 205 Ridgely Ave Annapolis, Md. 21401</b>							
31. DATE FILED (Month, Day, Year) <b>APR 24 1995</b>				32. REGISTRAR'S SIGNATURE <b>Julia Anderson-Rodell</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


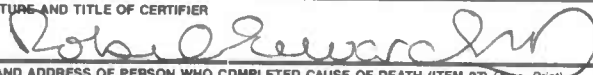
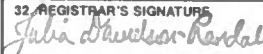
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14592

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Jennie Stephenson</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 30 1995</b>		3. TIME OF DEATH <b>550 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>265 - 24 - 9423</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 4, 1911</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Shady Grove Adventist Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Rockville</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>9701 Medical Center Drive</b>				10f. ZIP CODE <b>20850</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2 years</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Seamstress</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Garment Manufacturer</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Charles Accurso</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Katrina Tagliareno</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Joan M. Cox</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>230 New Mark Esplanade, Rockville, Maryland 20850</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Elmwood-St. Joseph Cemetery 5/3</b>		20c. LOCATION — City or Town, State <b>Mason City, Iowa</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>ventricular fibrillation</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Atherosclerotic heart disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death <b>6 min</b>  <b>4 yrs</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>D18026</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 30, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ROBIN EDWARDS MD 9901 Medical Center Dr Rockville MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 03 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14593

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Jack Silver</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>8</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>7:00 A M</b>	
4. SOCIAL SECURITY NUMBER <b>207-14-8957</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>66</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 18, 1928</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>11025 Seven Hill Lane</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Potomac</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Potomac</b>				10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>		10e. STREET AND NUMBER <b>11025 Seven Hill Lane</b>	
10f. ZIP CODE <b>20854</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES <b>Unavailable</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b> Specify: <b>XX</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Photographer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Audiovisual</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Max Silver</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Fannie Glickman</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Perri MacHugh Silver</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10</b>			
20a. METHOD OF DISPOSITION <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		20c. LOCATION — City or Town, State <b>4-9 Beltsville, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ellen H. Rapp</i>				22. NAME AND ADDRESS OF FACILITY <b>Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Respiratory Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Metastatic Cancer of Kidney</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>						Approximate Interval Between Onset and Death <b>Immediate</b> <b>3 months</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN</b>						24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>						26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>	
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James A. Posey, MD</i>				29c. LICENSE NUMBER <b>0101049619 VA</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 8, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>James A. Posey, M. D., 3800 Reservoir Road, NW, Washington, DC 20007</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 1995</b>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Amended #s 16 b, 18; 4/28/95, M. L. S., Allegany Co.

95 14594

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) AGNES Baxter SMALL				2. DATE OF DEATH MONTH DAY YEAR April 24, 1995		3. TIME OF DEATH 7:55 P M					
4. SOCIAL SECURITY NUMBER 212-24-0407		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 9, 1919		8. BIRTHPLACE (State or Foreign Country) West Virginia			
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland			9c. COUNTY OF DEATH Allegany				
10a. STATE WV				10b. COUNTY Mineral		10c. CITY, TOWN OR LOCATION Piedmont		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 47 East Hampshire Street				10f. ZIP CODE 26750		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE - American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk		16b. KIND OF BUSINESS/INDUSTRY Retailer Store							
17. FATHER'S NAME (First, Middle, Last) Sidney M. Eisler				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah B. Lawson							
19a. INFORMANT'S NAME (Type/Print) Sarah A. Henry				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 47 E. Hampshire St., Piedmont, WV 26750							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Union Cemetery April 28, 1995		20c. LOCATION - City or Town, State Meyersdale, Pa.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harold Dean Notarajan</i>				22. NAME AND ADDRESS OF FACILITY Markwood McKenzie Funeral Home 111 S. Mineral St., Keyser, WV 26726							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Carcinoma to Lung DUE TO (OR AS A CONSEQUENCE OF): b. Primary Unknown DUE TO (OR AS A CONSEQUENCE OF): c. Deep Venous Thrombosis Right Arm DUE TO (OR AS A CONSEQUENCE OF): d. Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death Oct. 1993 Oct. 1993 2 Weeks 5 Years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD						29c. LICENSE NUMBER D 23371		29d. DATE SIGNED (Month, Day, Year) April 25, 95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Qamar Zaman M.D. Suite 102 625 Kent Ave. Cumberland, MD 21502											
31. DATE FILED (Month, Day, Year) APR 27 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

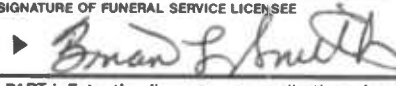

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14595

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HARRY EDWIN SUMMERS</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>20</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>11:06AM</b> M	
4. SOCIAL SECURITY NUMBER <b>218-16-2719</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>73</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 4, 1922</b>		8. BIRTHPLACE (State or Foreign Country) <b>West Virginia</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Sacred Heart Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>Allegany</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>WV</b>		10b. COUNTY <b>Mineral</b>		10c. CITY, TOWN OR LOCATION <b>Keyser</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>Rt. 1, Box 217</b>				10f. ZIP CODE <b>26726</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>World War II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Self Employed</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Timber-Pulpwood</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Blaine Newton Summers</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth Poling</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Helen Summers</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt. 1, Box 217 Keyser, WV 26726</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Stone Chapel Cemetery April 23, 1995 Burlington, WV</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Rotruck-Smith Funeral Home 85 S. Main Street Keyser, WV 26726</b>			
23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial infarction</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.							Approximate Interval Between Onset and Death <b>imm.</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Jeffrey Davis M.D.</b>				29c. LICENSE NUMBER <b>D35318</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 20, 95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Jeffrey Davis M.D. Sacred Heart Hosp. Cumberland MD</b>							
31. DATE FILED (Month, Day, Year) <b>4 APR 27 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 14596

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ELMER L. SHEETZ</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Apr. 24, 1995</b>		3. TIME OF DEATH <b>1:20 P M</b>	
4. SOCIAL SECURITY NUMBER <b>705-12-4667</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan 17, 1920</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>12918 N CRESAP STREET APT 50</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Cumberland</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>12918 N. Cresap Street Apt. 50</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Machinist</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Railroad</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George F. Sheetz</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Edna Kyne</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Lillie P. Sheetz</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12918 N. Cresap St. Apt. 50 Cumberland, MD 21502</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sunset Memorial Park</b>		DATE <b>04/27</b>		20c. LOCATION — City or Town, State <b>Cumberland, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>ADVANCED MULTIPLE MYELOMA</b>							<b>11/91</b>
b. <b>INTRACTABLE PAIN</b>							<b>11/91</b>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER <b>D23371</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 25, 95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Qamar Zaman; 625 Kent Avenue; Cumberland, MD 21502</b>							
31. DATE FILED <b>APR 26 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14597

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John SKOROBATSCH				2. DATE OF DEATH MONTH 4 DAY 18 YEAR 95		3. TIME OF DEATH 0756 M	
4. SOCIAL SECURITY NUMBER 218-48-8145		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 46 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-08-48	
9a. FACILITY NAME (If not institution, give street and number) Peninsula Regional				9b. CITY, TOWN OR LOCATION OF DEATH Salisbury		9c. COUNTY OF DEATH Wicomico	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Westover		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8579 Hood Rd.				10f. ZIP CODE 21871		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Army		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 2 Owner/operator		17. KIND OF BUSINESS/INDUSTRY Sign Company			
17. FATHER'S NAME (First, Middle, Last) Ivan Skorobatsch				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elsa Detke			
19a. INFORMANT'S NAME (Type/Print) Catherine B. Skorobatsch				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8579 Hood Rd., Westover, MD 21871			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Wicomico Memorial Park 4/21		20c. LOCATION — City or Town, State Salisbury, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Pulmonary Insufficiency					Approximate Interval Between Onset and Death Unknown
		b. Chronic Lung Disease					Years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER John T. Bulkeley, M.D., D.M.E.				29c. LICENSE NUMBER D03599		29d. DATE SIGNED (Month, Day, Year) 4-18-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John T. Bulkeley, M.D., 108 Pine Bluff Rd., Salisbury, Md. 21801							
31. DATE FILED (Month, Day, Year) APR 20 1995				32. REGISTRAR'S SIGNATURE John T. Bulkeley			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14598

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CALVIN KENNETH SNYDER				2. DATE OF DEATH MONTH DAY YEAR April 17, 1995		3. TIME OF DEATH 20 35 M	
4. SOCIAL SECURITY NUMBER 071-09-0709		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) December 10, 1909	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) Atlantic General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Berlin	
9c. COUNTY OF DEATH Worcester				10a. STATE Maryland			
10b. COUNTY Wicomico				10c. CITY, TOWN OR LOCATION Salisbury			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 755 Canvas Bac Court			
10f. ZIP CODE 21801				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Associate Executive		16b. KIND OF BUSINESS/INDUSTRY Trade Association	
17. FATHER'S NAME (First, Middle, Last) Joseph Snyder				18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace A. McGill			
19a. INFORMANT'S NAME (Type/Print) Richard D. Snyder				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 S. Hampton Bridge Rd., Salisbury, MD 21801			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Salisbury Crematory		DATE 4/22		20c. LOCATION — City or Town, State Salisbury, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>J. H. Holloway</i>				22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>URSEMIA</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <i>DEHYDRATION</i> b. DUE TO (OR AS A CONSEQUENCE OF): <i>ANEMIA</i> c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Other		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Steve Winters MD				29c. LICENSE NUMBER D27993		29d. DATE SIGNED (Month, Day, Year) 4/18/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Steve Winters MD #3 Bay Street Berlin MD 21811							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE <i>J. H. Holloway</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14599

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Emmett Scott Smith</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>20</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>0625</b> M	
4. SOCIAL SECURITY NUMBER <b>218-07-5027</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 21, 1915 Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Wicomico</b>		10c. CITY, TOWN OR LOCATION <b>Salisbury</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1005 Marquis Avenue</b>				10f. ZIP CODE <b>21801</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>		15b. KIND OF BUSINESS/INDUSTRY <b>None</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Billy Williams</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sarah Williams</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Lizzie Smith</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1005 Marquis Ave. Salisbury, Md. 21801</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Springhill Gardens</b>		DATE <b>4/24</b>		20c. LOCATION — City or Town, State <b>Hebron, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Bladys B. Stewart</b>				22. NAME AND ADDRESS OF FACILITY <b>Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis Shock</b>							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>026612</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-20-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>105 Pwz Bluff, Salisbury MD 21801</b>							
31. DATE FILED (Month, Day, Year) <b>APR 21 1995</b>				32. REGISTRAR'S SIGNATURE <b>John D. Anderson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14600

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jackie A. Sterling				2. DATE OF DEATH MONTH DAY YEAR April 25, 1995		3. TIME OF DEATH 9:12 a. m.	
4. SOCIAL SECURITY NUMBER 218-16-8830		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 17, 1924	
9a. FACILITY NAME (If not institution, give street and number) Edw.W.McCready Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Crisfield		9c. COUNTY OF DEATH Somerset	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Crisfield		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 26392 E. Pear St.				10f. ZIP CODE 21817		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W. W. II- U.S. Navy		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) H. S. Graduate		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Tower Operator		16b. KIND OF BUSINESS/INDUSTRY Chesapeake Plywood			
17. FATHER'S NAME (First, Middle, Last) Jackson W. Sterling				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marion D. Hoffman			
19a. INFORMANT'S NAME (Type/Print) Myrtle L. Sterling (Wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26392 E. Pear St. - Crisfield, MD 21817			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sunnyridge Memorial Park-4/27/95		20c. LOCATION — City or Town, State Crisfield, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert H. Bradshaw, Jr.				22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons Funeral Home 306 W. Main St.- Crisfield, MD 21817			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Cerebral Vascular Accident					
		b. due to thrombosis middle					
		c. Cerebral Artery					
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER M. D. Barhan				29c. LICENSE NUMBER 12764		29d. DATE SIGNED (Month, Day, Year) 4/26/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. M. D. Barhan, Rt. #413, Crisfield, Md. 21817							
31. DATE FILED (Month, Day, Year) APR 27 1995				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.




IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14601

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) David A. Stout				2. DATE OF DEATH MONTH DAY YEAR April 26, 1995		3. TIME OF DEATH 0125 M	
4. SOCIAL SECURITY NUMBER 221-60-0107		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 18 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 14, 1976	
9a. FACILITY NAME (If not institution, give street and number) 223 Nellie's Corner Road				9b. CITY, TOWN OR LOCATION OF DEATH Rising Sun		9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Rising Sun		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 223 Nellie's Corner Road				10f. ZIP CODE 21911		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Student		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Franklin Burleigh Stout				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Mary Blissick			
19a. INFORMANT'S NAME (Type/Print) Franklin B. Stout				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 223 Nellie's Corner Road - Rising Sun, MD 21911			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Immaculate Conception Cem. 4-29-95		20c. LOCATION — City or Town, State Cherry Hill, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 West Stockton Street Elkton, MD 21921-5521			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>Ewing's Sarcoma</u> DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death 16 months	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		c. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER C10000964		29d. DATE SIGNED (Month, Day, Year) 4/27/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) T. Wozniak, M.D. - 4745 Ogletown-Stanton Road, Suite 116 - Newark, DE 19713							
31. DATE FILED (Month, Day, Year) APR 28 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14602

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mildred V. Schmidt		2. DATE OF DEATH MONTH DAY YEAR April 24 1995		3. TIME OF DEATH 7:12 A M	
4. SOCIAL SECURITY NUMBER 221-01-9926		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.	
7. DATE OF BIRTH (Month, Day, Year) 9-4-10		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Union Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Elkton		9c. COUNTY OF DEATH Cecil	
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Cecilton	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 114 West Main Street		10f. ZIP CODE 21913	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Executive Secretary		17. KIND OF BUSINESS/INDUSTRY duPont Company	
18. FATHER'S NAME (First, Middle, Last) John S. Vinson		19. MOTHER'S NAME (First, Middle, Maiden Surname) Williard R. Baker			
20. INFORMANT'S NAME (Type/Print) George M. Schmidt		21. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 114 West Main St. Cecilton, Md. 21913			
22. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		23. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Stephens Cem. 4/27/95		24. LOCATION — City or Town, State Earleville, Md.	
25. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		26. NAME AND ADDRESS OF FACILITY Gee Funeral Home 259 E. Main St., Elkton, Md. 21921			
27. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Chronic Obstructive Pulmonary Disease</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____		Approximate Interval Between Onset and Death 5 yrs			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Severe Arteriosclerosis</u> <u>Alzheimer's Disease</u> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		28a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
29. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		30. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
31. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		32a. DATE OF INJURY (Month, Day, Year)		32b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
32c. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		32d. DESCRIBE HOW INJURY OCCURRED		32e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
33a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		33b. SIGNATURE AND TITLE OF CERTIFIER <i>Wallace Obenshain M.D.</i>		33c. LICENSE NUMBER D-07129	
33d. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Wallace Obenshain, M.D. Route 213 Cecilton, Md. 21913		33e. DATE SIGNED (Month, Day, Year) 24 Apr 95			
34. DATE FILED (Month, Day, Year) APR 26 1995		35. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14603

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert Leonard Souder				2. DATE OF DEATH MONTH DAY YEAR April 28, 1995		3. TIME OF DEATH 11:04 A M	
4. SOCIAL SECURITY NUMBER 220-26-4393		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) February 8, 32	
9a. FACILITY NAME (If not institution, give street and number) Physicians Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH La Plata		9c. COUNTY OF DEATH Charles	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Charles		10c. CITY, TOWN OR LOCATION White Plains		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 10455 Willets Crossing Road				10f. ZIP CODE 20695		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No -- If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE -- American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Lineman		16b. KIND OF BUSINESS/INDUSTRY Pepco	
17. FATHER'S NAME (First, Middle, Last) Raymond Jennings Souder				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alberta Mary Weidman			
19a. INFORMANT'S NAME (Type/Print) Robert K. Souder				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7570 Poplar Street, Charlotte Hall, Md. 20622			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Duration 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Trinity Memorial Gdns. May 2, 1995		20c. LOCATION -- City or Town, State Waldorf, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE MgB Mark G. Brohawn M00053				22. NAME AND ADDRESS OF FACILITY THE HUNT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARDIAC ARRHYTHMIA							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY -- At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 2 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Benjers M				29c. LICENSE NUMBER D-28281		29d. DATE SIGNED (Month, Day, Year) 4/29/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Nelson V. Benjers, M.D. 8926 Woodyard Road, #102 Clinton, Maryland 20735							
31. DATE FILED (Month, Day, Year) MAY 02 1995				32. REGISTRAR'S SIGNATURE Julia Dawson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14604

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Earl Austin Smith</b>				2. DATE OF DEATH <b>April 26, 1995</b> YEAR MONTH DAY		3. TIME OF DEATH <b>19:00</b>	
4. SOCIAL SECURITY NUMBER <b>220-20-5772</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>66</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>August 31, 1928</b>		8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Calvert Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Prince Frederick</b>		9c. COUNTY OF DEATH <b>Calvert</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Calvert</b>		10c. CITY, TOWN OR LOCATION <b>Lusby</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>440 Lake Drive</b>		10f. ZIP CODE <b>20657</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Caucasian</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Sales</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Sporting Goods</b>		17. FATHER'S NAME (First, Middle, Last) <b>Austin Millard Smith</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Louise Shaver</b>				19a. INFORMANT'S NAME (Type/Print) <b>Lillian E. Smith</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>440 Lake Drive, Lusby, Maryland 20657</b>	
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lee Crematory 4/28/95</b>		20c. LOCATION — City or Town, State <b>Clinton, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Charles F. Bell, Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>Bell Funeral Services MD 20678 P.O. Box 119, Wilson Court, Prince Frederick</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>breast infection</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>per cirrhosis</b> c. <b>alcohol abuse</b> d. <b>30 years</b> Approximate Interval Between Onset and Death <b>1 week</b> <b>10 years</b> <b>30 years</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>D46314</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 27, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Pomilla Prince Frederick MD. 20678</b>							
31. DATE FILED (Month, Day, Year) <b>APR 28 1995</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

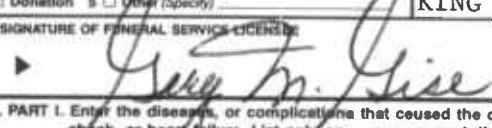
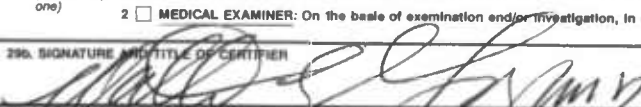

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14605

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JANET L. TAYLOR</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>27</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>3:20 A. M.</b>	
4. SOCIAL SECURITY NUMBER <b>577-40-8445</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>63</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAR. 26, 1932</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRING</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>SILVER SPRING</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>1511 KORTH PLACE</b>		10f. ZIP CODE <b>20902</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>OWN HOME</b>	
17. FATHER'S NAME (First, Middle, Last) <b>SAM KLEIN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>RUTH ARONSOHN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ALAN TAYLOR (SON)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9 FAIRDALE CT., SILVER SPRING, MD 20905</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>KING DAVID MEMORIAL GARDEN 4/30</b>		20c. LOCATION — City or Town, State <b>FALLS CHURCH, VIRGINIA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. OVARIAN CANCER</b> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate interval Between Onset and Death <b>2 MONTHS</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PULMONARY EMBOLISM</b> <b>PULMONARY FAILURE</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>DD1120</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 27, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>WALTER E. GOODE MD 2309 SHOREFIELD ROAD WHITEHARTON, MD 20902</b>							
31. DATE FILED (Month, Day, Year) <b>APR 28 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

10

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14606

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Edward THOMAS</b>		2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 15 1995</b>		3. TIME OF DEATH <b>6:30am</b>	
4. SOCIAL SECURITY NUMBER <b>212-34-1899</b>	5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>58</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>NOV. 23 1936</b>	8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>ANNE ARUNDEL MEDICAL CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>ANNAPOLIS</b>		9c. COUNTY OF DEATH <b>ANNE ARUNDEL</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ANNE ARUNDEL</b>		10c. CITY, TOWN OR LOCATION <b>ANNAPOLIS</b>	
10d. IHSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1000 MADISON STREET AAPT. 4 A</b>		10f. ZIP CODE <b>21403</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <b>3</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1955 - 1957</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>SUPERVISOR</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SUPERVISOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>A.A. CO. WASTE PLANT</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOSEPH G. THOMAS</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MAGGIE JOHNSON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>DORIS THOMAS</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>332 FOREST BEACH RD. ANNAPOLIS, MD. 21401</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MARYLAND VETERAN CEMETERY 4/20/95</b>		20c. LOCATION — City or Town, State <b>CROWNSVILLE, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Larry H. Reese</b>		22. NAME AND ADDRESS OF FACILITY <b>REESE &amp; SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hepato renal syndrome</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Hepatic insufficiency</b> <b>Hypertension - Alcohol</b>					Approximate Interval Between Onset and Death <b>2 days</b> <b>1 year</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes - Hypoglycemia</b>					24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <b>1</b> <input type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Michael M. Adja-Gordon</b>		29c. LICENSE NUMBER <b>D31998</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/15/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Michael M. Adja-Gordon 205 Ridgely Ave Annapolis 21401</b>					
31. DATE FILED (Month, Day, Year) <b>APR 24 1995</b>		32. REGISTRAR'S SIGNATURE <b>John A. Hunsicker-Rodell</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[The body of the document contains several paragraphs of extremely faint, illegible text. The text appears to be organized into sections, possibly separated by headings or subheadings, but the specific content cannot be discerned due to the low contrast and quality of the scan.]



95 14607

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>James Raymond Tomlinson</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 8, 1995</b>		3. TIME OF DEATH M <b>2131</b>	
4. SOCIAL SECURITY NUMBER <b>216-14-5228</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec 15, 1918</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Calvert Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Prince Frederick</b>		9c. COUNTY OF DEATH <b>Calvert</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>Calvert</b>		10c. CITY, TOWN OR LOCATION <b>Huntingtown</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>1930 Kings Landing Road</b>				10f. ZIP CODE <b>20639</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>Transit driver</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Transit driver</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Metro. Transit Bus</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Tomlinson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Minnie Garner</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Gladys M. Tomlinson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as # 10 above</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Ft. Lincoln Cemetery 4-11-95</b>		20c. LOCATION — City or Town, State <b>Brentwood, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William R. J.</i>				22. NAME AND ADDRESS OF FACILITY <b>Rausch Funeral Home, PA, Owings, MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>infarct MYOCARDIAL INFARCTION (MI)</b> Approximate interval Between Onset and Death <b>45 Minutes</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. <b>3 DAYS OF</b> c. <b>CHST PAIN</b> d. <b>CHST PAIN FOR 3 DAYS PER WIFE - NO DOCTOR CONSULTED</b> PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHST PAIN FOR 3 DAYS PER WIFE - NO DOCTOR CONSULTED</b> 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>10-8-85</b>		28b. TIME OF INJURY <b>930 P</b> M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John C. Norwood MD</i>				29c. LICENSE NUMBER <b>D43689</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-8-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Type/Print) <i>John C. Norwood MD</i>							
31. DATE FILED (Month, Day, Year) <b>APR 10 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10+1



Ann #. 19, B 4-11-95 BCB P.G.C.

95 14608

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HENRY Sylvester THOMAS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Apr. 6, 1995</b>		3. TIME OF DEATH <b>8:08 A M</b>	
4. SOCIAL SECURITY NUMBER <b>220-28-5719</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 17, 1933 Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1116 Carrington Avenue</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Seat Pleasant</b>		9c. COUNTY OF DEATH <b>Prince George's</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Seat Pleasant</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1116 Carrington Avenue</b>				10f. ZIP CODE <b>20743</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>8th Grade</b> College (1-4 or 5+) <b>Operation Manager</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Private</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Henry D. Thomas</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rosie Smith</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Helen Thomas/Wife</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1116 Carrington Avenue Seat Pleasant, Maryland 20785 20743</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Harmony Memorial Park 4-11 Landover, Maryland</b>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Quawana J. Braxton</b>				22. NAME AND ADDRESS OF FACILITY <b>J.B. Jenkins Funeral Home 7474 Landover Road, Landover, Md. 20785</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardio-Respiratory Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Partial Intestinal Obstruction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Metastatic Carcinoma of Colon</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>4/6/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. Theodore Watkins 8115 Fenton Street Silver Spring, md 20910</b>							
31. DATE FILED (Month, Day, Year) <b>APR 07 1995</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14609

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ESTELLA GLADYS TATE</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>31</b> , YEAR <b>1995</b>		3. TIME OF DEATH <b>10:52A</b>	
4. SOCIAL SECURITY NUMBER <b>229-36-4615</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>63</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jul. 17, 1931</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Prince George's Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cheverly</b>		9c. COUNTY OF DEATH <b>Prince George's</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Lanham</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>9937 Franklin Street</b>				10f. ZIP CODE <b>20706</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Sales Associate</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Private</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Issac Robinson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lillie Mae Fitchell</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Lloyd Tate/Husband</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9937 Franklin Street Lanham, Maryland 20706</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Harmony Memorial Park 4-6</b>		20c. LOCATION — City or Town, State <b>Landover, Maryland</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Mawana L. Braxton</b>				22. NAME AND ADDRESS OF FACILITY <b>J.B. Jenkins Funeral Home 7474 Landover Road, Landover, MD 20785</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Ventricular Arrhythmia</b> DUE TO (OR AS A CONSEQUENCE OF):					
		b. <b>Coronary Artery Disease</b> DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Renal Failure</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Beyan MD (Doc)</b>		29c. LICENSE NUMBER <b>D25925</b>		29d. DATE SIGNED (Month, Day, Year) <b>March 31, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. BERGER MD #205, 7720 Wisconsin Ave, Bethesda, Md 20814</b>							
31. DATE FILED (Month, Day, Year) <b>APR 03 1995</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 14610

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LAURA BELLE Truitt				2. DATE OF DEATH MONTH DAY YEAR April 18, 1995		3. TIME OF DEATH 2330 M	
4. SOCIAL SECURITY NUMBER 214-10-9724		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 15, 1904	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY	
9c. COUNTY OF DEATH WICOMICO				10a. STATE Maryland		10b. COUNTY Wicomico	
10c. CITY, TOWN OR LOCATION Salisbury				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 521 Alabama Ave., Apt. 9	
10f. ZIP CODE 21801				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Hosiery Mill		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Merrill J Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Beebe			
19a. INFORMANT'S NAME (Type/Print) Joan Causey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 314 Brewington Dr., Salisbury, MD 21801			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parsons Cemetery 4/21		20c. LOCATION — City or Town, State Salisbury, MD 21801	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.R. Holloway</i>				22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiac Failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Cancer of Colon</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Craig J. Schaeffer</i>				29c. LICENSE NUMBER D26040		29d. DATE SIGNED (Month, Day, Year) April 19, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CRAIG J. SCHAEFFER 551 Riverside DR Salisbury, MD							
31. DATE FILED (Month, Day, Year) APR 20 1995				32. REGISTRAR'S SIGNATURE <i>Jane A. H. H. H.</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



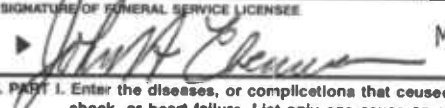
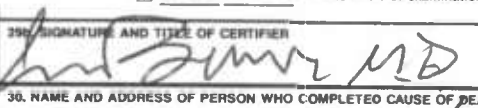





95 14612

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>VIOLET LOUISE TAYLOR</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>21</b> , YEAR <b>1995</b>		3. TIME OF DEATH <b>3:55 P M</b>	
4. SOCIAL SECURITY NUMBER <b>578-28-7419</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 21, 1910</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Wellington Manor Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Clinton</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGE'S</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Clinton</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>9211 Stewart Lane</b>			
10f. ZIP CODE <b>20735</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Harry E. Tippet</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary C. Steed Tippet</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Tracy L. Burnette-Keech</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10590 S. Faulkner Road Faulkner, MD 20632</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory 4-23-95</b>		20c. LOCATION — City or Town, State <b>Alexandria, VA</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>M00173</b>	
22. NAME AND ADDRESS OF FACILITY <b>J.H. Eberwein Mortuary</b> <b>4433 White Plains Lane White Pls., MD</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Hypotension</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>dehydration</b> DUE TO (OR AS A CONSEQUENCE OF): <b>organic brain syndrome</b>		Approximate Interval Between Onset and Death <b>10h</b> <b>16h</b> <b>38</b> <b>4h</b>		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Attending</b>	
29c. LICENSE NUMBER <b>D-24535</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/22/95</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>7700 Old Branch Avenue C-101 Clinton, Maryland 20735</b>		31. DATE FILED (Month, Day, Year) <b>APR 27 1995</b>	
32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

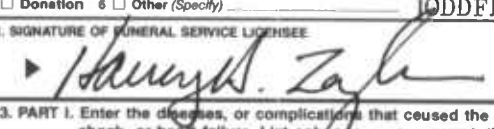
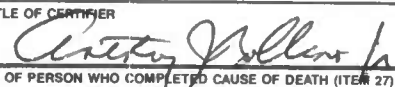

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14613

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>PEARL ROSELLA USORIS</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>23</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>0844 A M</b>	
4. SOCIAL SECURITY NUMBER <b>217 10 5729</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
9a. FACILITY NAME (If not institution, give street and number) <b>MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>				9c. COUNTY OF DEATH <b>ALLEGANY</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>ALLEGANY</b>		10c. CITY, TOWN OR LOCATION <b>ELLERSLIE</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>P O BOX 2</b>				10f. ZIP CODE <b>21529</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>HOMEMAKER</b>	
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>				16b. KIND OF BUSINESS/INDUSTRY <b>HOME</b>				17. FATHER'S NAME (First, Middle, Last) <b>OWEN ZEIGLER</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>HATTIE VIOLA KIMMEL</b>				19a. INFORMANT'S NAME (Type/Print) <b>R. STEVEN MASON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P O BOX 187, ELLERSLIE, MD 21529</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ODDFELLOW CEMETERY APR 26, 1995</b>				20c. LOCATION — City or Town, State <b>STOYSTOWN, PA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>HARVEY H. ZEIGLER FUNERAL HOME HYNDMAN, PA 15545-0636</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACUTE CONGESTIVE HEART FAILURE</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  a. <b>ATHERIOSCLEROSIS</b> b. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DDA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D17565</b>				29d. DATE SIGNED (Month, Day, Year) <b>Apr 23, '95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR ANTHONY BOLLINO 955 FREDERICK STREET, CUMBERLAND, MD 21502</b>				31. DATE FILED (Month, Day, Year) <b>APR 27 1995</b>				32. REGISTRAR'S SIGNATURE 	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Gordon Dale Volz</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 5, 1995</b>		3. TIME OF DEATH <b>4:25 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>189-24-6168</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>63</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>06/30/31</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>6025 Eldorado Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rhodesdale</b>		9c. COUNTY OF DEATH <b>Dorchester</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Dorchester</b>		10c. CITY, TOWN OR LOCATION <b>Rhodesdale</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>6025 Eldorado Road</b>				10f. ZIP CODE <b>21659</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12th</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Photographer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Photography</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Richard A. Volz, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Isabelle Mackay</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Joyce Ann Jones</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6025 Eldorado Rd., Rhodesdale, MD 21659</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cambridge Crematory</b>		DATE <b>4-8</b>		20c. LOCATION — City or Town, State <b>Cambridge, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Michael F. Eskow</b>				22. NAME AND ADDRESS OF FACILITY <b>Framptom-Hawkins-Eskow Funeral Home</b> <b>PO Box 43, Federalsburg, MD 21632</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.						Approximate interval between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO <b>INSPECTION</b>	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dennis J. Chute</b>				29c. LICENSE NUMBER <b>O.C.M.E</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 5, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. DENNIS CHUTE M.D. 111 PENN STREET, BALTIMORE.MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>APR 11 '95</b>		32. REGISTRAR'S SIGNATURE <b>Jake Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

1. DECEDENT'S NAME (First, Middle, Last) <b>MARTIN G. VERMILLION</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>27</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>1:00 PM</b>	
4. SOCIAL SECURITY NUMBER <b>577-07-9923</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>January 2, 1910</b>		8. BIRTHPLACE (State or Foreign Country) <b>Washington DC</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Southern Maryland Hospital Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Clinton</b>				9c. COUNTY OF DEATH <b>Prince George's</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Charles</b>		10c. CITY, TOWN OR LOCATION <b>Waldorf</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2008-C Wedgewood Place</b>				10f. ZIP CODE <b>20602</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Sheet Metal Worker</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Roofing/Construction</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Walter J. Vermillion</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Daisy M. McCarthy</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Herbert S. Vermillion</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8705 Penns Hill Road, La Plata, Maryland 20646</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Trinity Memorial Gardens 5-01-95</b>		20c. LOCATION — City or Town, State <b>Waldorf, Maryland</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Mark G. Brohawn</b> M00053				22. NAME AND ADDRESS OF FACILITY <b>THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary arrest</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Sepsis</b>								Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic obstructive lung disease</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Me... MD</b>				29c. LICENSE NUMBER <b>024020</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-27-95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MOTI L KOUL M.D 3710 Riverside St #20 Temple Hills MD 20746</b>									
31. DATE FILED (Month, Day, Year) <b>MAY 02 1995</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson</b>							



Amended #4, 5/3/95 MRT Montgomery County 95 14616  
FOR  
1 - STATE  
REGISTRAR  
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH  
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEDENT'S NAME (First, Middle, Last) ALICE MACY WHITE				2. DATE OF DEATH MONTH DAY YEAR APRIL 21 1995		3. TIME OF DEATH 8:10 p.m.			
4. SOCIAL SECURITY NUMBER 213-52-0988 483-48-2576		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT 10 1910		8. BIRTHPLACE (State or Foreign Country) KANSAS	
9a. FACILITY NAME (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER RESIDENCE OF DECEDENT				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA				9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION KENSINGTON				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 11100 LUND PLACE				10f. ZIP CODE 20895		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER			16b. KIND OF BUSINESS/INDUSTRY OWN HOME		
17. FATHER'S NAME (First, Middle, Last) WILLIAM LEWIS MACY				18. MOTHER'S NAME (First, Middle, Maiden Surname) ALICE JAMES					
19a. INFORMANT'S NAME (Type/Print) THEODORE G. WHITE, III				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2062 FARMINGTON TURN WESTLAKE, OH. 44145					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. COMFORT CREMATORY 4/25		20c. LOCATION — City or Town, State ALEXANDRIA, VA.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Vernon Simmons</i>				22. NAME AND ADDRESS OF FACILITY JOSEPH GOWLER'S SONS FUNERAL HOME 5130 WISCONSIN AVE NW, WASHINGTON D.C.					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DILATED CARDIOMYOPATHY DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death 24 hours			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER J. H. KELLOGG, M.D.				29c. LICENSE NUMBER MD047454 PENNSYLVANIA		29d. DATE SIGNED (Month, Day, Year) APRIL 22 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. H. KELLOGG, M.D., NATIONAL NAVAL MEDICAL CENTER BETHESDA, MD 20889-5000									
31. DATE FILED (Month, Day, Year) APR 25 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>					



95 14617

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Charlotte Ann Wood</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>19</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>12:05 PM</b>	
4. SOCIAL SECURITY NUMBER <b>208-28-9264</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>56</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan 30, 1939</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Shady Grove Adventist Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Pennsylvania</b>				10b. COUNTY <b>Wayne</b>		10c. CITY, TOWN OR LOCATION <b>Honesdale</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>RD5, Box 670</b>			
10f. ZIP CODE <b>18431</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>-</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Jack Baldwin</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Charlotte Robbins</b>			
19a. INFORMANT'S NAME (Type/Print) <b>William H. Wood</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18806 Birdseye Drive, Germantown, Maryland 20874</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc. April 21, 1995</b>		20c. LOCATION — City or Town, State <b>Bethesda, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSÉE <b>Nichole P. Kutta</b> M00348				22. NAME AND ADDRESS OF FACILITY <b>Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MASSIVE SUBARACHNOID HEMORRHAGE</b> DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Hypertension</b>							Approximate Interval Between Onset and Death <b>4 days</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>John J. May</b>				29c. LICENSE NUMBER <b>027610</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 20, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FRANK J. MAYO, MD 16220 Frederick Rd. #213, Bethesda, MD 20877</b>							
31. DATE FILED (Month, Day, Year) <b>APR 24 1995</b>				32. REGISTRAR'S SIGNATURE <b>John A. Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

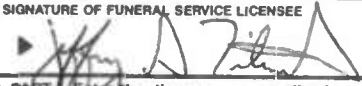

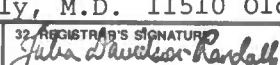




95 14618

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jeannie C. Williams				2. DATE OF DEATH MONTH DAY YEAR April 24, 1995		3. TIME OF DEATH 4:30 P M	
4. SOCIAL SECURITY NUMBER 014 18 8078		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 29, 1920	
8. BIRTHPLACE (State or Foreign Country) Massachusetts				9a. FACILITY NAME (If not institution, give street and number) 11912 Renwood Lane		9b. CITY, TOWN OR LOCATION OF DEATH Rockville	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Rockville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 11912 Renwood Lane	
10f. ZIP CODE 20852				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY Government	
17. FATHER'S NAME (First, Middle, Last) James Cameron				18. MOTHER'S NAME (First, Middle, Maiden Surname) Beatrice Caswell			
19a. INFORMANT'S NAME (Type/Print) Louis L. Williams, III				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11912 Renwood Lane, Rockville, Maryland 20852			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) April 26, 1995 Montgomery Crematorium, Inc.		20c. LOCATION — City or Town, State Bethesda, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00689				22. NAME AND ADDRESS OF FACILITY Robert A. Humphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio pulmonary Arrest DUE TO (OR AS A CONSEQUENCE OF): b. Metastatic Malignant Melanoma DUE TO (OR AS A CONSEQUENCE OF): c. Breast Cancer DUE TO (OR AS A CONSEQUENCE OF): d. Liver Failure							Approximate Interval Between Onset and Death 1 Minute 1 Month 5 Years 1 Month
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ocular Melanoma							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER  M.D.				29c. LICENSE NUMBER P 39120		29d. DATE SIGNED (Month, Day, Year) April 25, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joseph Garrett Reilly, M.D. 11510 Old Georgetown Road, Rockville, MD 20852							
31. DATE FILED APR 27 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14619

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Alma Sylvia Walker				2. DATE OF DEATH MONTH DAY YEAR April 25, 1995				3. TIME OF DEATH 8:45 A M			
4. SOCIAL SECURITY NUMBER 579-46-8257		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 28, 1905		8. BIRTHPLACE (State or Foreign Country) England			
9a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis				9c. COUNTY OF DEATH Anne Arundel			
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Highland				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 7805 Brown Bridge Road				10f. ZIP CODE 20777		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bindery Worker			16b. KIND OF BUSINESS/INDUSTRY U.S. Government				
17. FATHER'S NAME (First, Middle, Last) Osborne George Barker				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lydia Anne Vaughan							
19a. INFORMANT'S NAME (Type/Print) M. Clive Walker				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7805 Brown Bridge Road, Highland, MD 20777							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery 4/28/95		20c. LOCATION — City or Town, State Brentwood, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Sil. Spr. MD 20901							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute and Chronic Recurrent Left Ventricular DUE TO (OR AS A CONSEQUENCE OF): b. Failure Due to a Recent Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 4 mos.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Peter F. Verkouw, M.D. 1833-A Forest Drive, Annapolis, MD 21401				29c. LICENSE NUMBER D11653		29d. DATE SIGNED (Month, Day, Year) April 26, 1995					
31. DATE FILED (Month, Day, Year) APR 28 1995		32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Amended # 1, 4/28/95, J.W., Montgomery Co.

95 14620

1 - STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Harry Fenton <u>Walter, Walters- Jr.</u>				2. DATE OF DEATH MONTH DAY YEAR April 27, 1995		3. TIME OF DEATH 2:30 a m			
4. SOCIAL SECURITY NUMBER 578-01-2933		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 10, 1917		8. BIRTHPLACE (State or Foreign Country) Washington, DC	
9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park			9c. COUNTY OF DEATH Montgomery		
10a. STATE Maryland			10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1121 University Blvd., West #418				10f. ZIP CODE 20902		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 12			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Instrument Maker		16b. KIND OF BUSINESS/INDUSTRY U.S. Government				
17. FATHER'S NAME (First, Middle, Last) Harry F. Walter, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) May E. Sansbury					
19a. INFORMANT'S NAME (Type/Print) Elsie M. Walter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1121 University Blvd., West #418 Silver Spring, MD 20902					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 4/27/95		OATE		20c. LOCATION — City or Town, State Alexandria, VA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Marjorie Wilk</i>				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr.MD 20901					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Myocardial Failure</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Coronary Artery Disease</u> DUE TO (OR AS A CONSEQUENCE OF): d.  Approximate Interval Between Onset and Death 2 days 3 days /									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. [Signature]</i>				29c. LICENSE NUMBER D28883		29d. DATE SIGNED (Month, Day, Year) April 27, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) DR. ANJUN SAGI 1706 NEW HAMP AVE NW Washington DC 20009									
31. DATE FILED (Month, Day, Year) APR 28 1995		32. REGISTRAR'S SIGNATURE <i>Julia [Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14621

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ALVIN FRANK WACHTER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 13, 1995</b>		3. TIME OF DEATH <b>7:50 PM</b>	
4. SOCIAL SECURITY NUMBER <b>217-20-0248</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7/13/1927</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>4521 Rosemary Way</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Street</b>			9c. COUNTY OF DEATH <b>Harford</b>		
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Street</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4521 Rosemary Way</b>				10f. ZIP CODE <b>21154</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>World War II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>- -</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Mail Carrier</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Postal Service</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Jacob Wachter</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Eva Goralski</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Hilda A. Wachter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Highview Mem. Gardens</b>		20c. LOCATION — City or Town, State <b>4/17 Fallston, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>M. Shadon Runkle</i>				22. NAME AND ADDRESS OF FACILITY <b>Kurtz Funeral Home Jarrettsville, Maryland</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute myocardial infarction</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <b>3</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Lawrence Boms MD</i>				29c. LICENSE NUMBER <b>D15871</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/19/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>L. B. Boms 54 Scott Adam Rd Cockeysville Md 21030</b>							
31. DATE FILED (Month, Day, Year) <b>APR 20 1995</b>		32. REGISTRAR'S SIGNATURE <i>Jane Shadon Runkle</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Y. N. I. V.

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[illegible]



REG. NO.

DMMH-16 Rev 1/89



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH REG. NO.

REG. NO.

1. DECEDENT NAME (First, Middle, Last) <b>George Ellsworth Winters</b>		2. DATE OF DEATH MONTH DAY YEAR <b>April 21, 1995</b>		3. TIME OF DEATH <b>11:45 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>212-10-6266</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.	
		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) <b>August 9, 1918 Md</b>		8. BIRTHPLACE (State or Foreign Country)			
9a. FACILITY NAME (If not institution, give street and number) <b>102 State Rt.36 North</b>			9b. CITY, TOWN OR LOCATION OF DEATH <b>Lonaconing</b>		9c. COUNTY OF DEATH <b>Allegany</b>
<b>RESIDENCE OF DECEDENT</b>					
10a. STATE <b>Md</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Lonaconing</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>102 State Rt.36 North</b>			10f. ZIP CODE <b>21539</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Textile</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Spinner</b>
17. FATHER'S NAME (First, Middle, Last) <b>James Albert Winters</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Myrtle Hite</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Glenna Winters</b>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>102 State Rt.36 North, Lonaconing, Md. 21539</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Frostburg Mem.Park April 24, 1995</b>		20c. LOCATION — City or Town, State <b>Frostburg, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			22. NAME AND ADDRESS OF FACILITY <b>Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539</b>		
23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Self Inflicted Gun Shot Wound to the Head</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <b>b. Metastatic Squamous Cell Carcinoma of the Lungs</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>c.</b> _____ DUE TO (OR AS A CONSEQUENCE OF):  <b>d.</b> _____					Approximate Interval Between Onset and Death <b>Sudden</b>  <b>2 years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>April 21, 1995</b>		28b. TIME OF INJURY <b>10:45 A.M.</b>	
		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED <b>Self Inflicted Gun Shot Wound</b>	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Garage, Residence</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>102 State Rt.36 N Lonaconing, Md.</b>	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER 			29c. LICENSE NUMBER <b>D09157</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 21, 1995</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Paul Snow MD., 124 W. 3rd. St., Cumberland, Md. 21502</b>					
31. DATE FILED (Month, Day, Year) <b>APR 24 1995</b>		32. REGISTRAR'S SIGNATURE 			



95-2487-001

DWG

ITEMS: 23 PART I, 27, PER MEO FILM G-724 6/15/95 t.t  
ITEM 1. PER F.H. FILM G-723 5/10/95 t.t

95 14624

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <del>ANDRE</del> ANDRE RASHAD WOODS				2. DATE OF DEATH MONTH DAY YEAR APRIL 28 95		3. TIME OF DEATH 4:55A M	
4. SOCIAL SECURITY NUMBER NONE ISSUED		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS 2 20		7. DATE OF BIRTH (Month, Day, Year) February 28, 1995	
9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER Fort Cumberland Homes Apt. - 10-B				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="radio"/> College (1-4 or 5+) <input type="radio"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) infant		16b. KIND OF BUSINESS/INDUSTRY infant			
17. FATHER'S NAME (First, Middle, Last) Cornelius Graves				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lea R. Woods			
19a. INFORMANT'S NAME (Type/Print) Kevin Woods				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21502 Fort Cumberland Homes - 10-B Cumberland, Md.			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cemetery May 2, 1995		20c. LOCATION — City or Town, State Cumberland, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ernest A. Riley, Jr.				22. NAME AND ADDRESS OF FACILITY Leasure-Stein, Inc. 230 Baltimore Avenue Cumberland, Md. 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SUDDEN INFANT DEATH SYNDROME DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input checked="" type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dennis J. Chute MD				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) APRIL 28/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND 21201							
31. DATE FILED (Month, Day, Year) MAY 10 1995							

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14625

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) IRENE LORETTA Wood				2. DATE OF DEATH MONTH DAY YEAR APRIL 20 1995		3. TIME OF DEATH 0530 M	
4. SOCIAL SECURITY NUMBER 212-20-0064		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 24, 1926	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY	
9c. COUNTY OF DEATH WICOMICO				10a. STATE Maryland		10b. COUNTY Garrett	
10c. CITY, TOWN OR LOCATION McHenry				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER Joyes Run Rd.	
10f. ZIP CODE 21541				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Michael Sullivan				18. MOTHER'S NAME (First, Middle, Maiden Surname) Loretta Eisenhower			
19a. INFORMANT'S NAME (Type/Print) Amanda Fooks				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30770 Johnson Rd., Salisbury, MD 21801			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sang Run Cemetery 4/26			
20c. LOCATION — City or Town, State McHenry, MD				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John A. Holloway</i>			
22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Breast Cancer</i> DUPLICATE b. <i>Diagnosis</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. d. e. f. Approximate Interval Between Onset and Death Years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>John A. Holloway</i>			
29c. LICENSE NUMBER D34768				29d. DATE SIGNED (Month, Day, Year) 4/20/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NEFFAN HILLMAN MD 560 RIVERSIDE DR. B101 SALISBURY, MD 21801				31. DATE FILED (Month, Day, Year) APR 24 1995			
32. REGISTRAR'S SIGNATURE <i>John A. Holloway</i>				33. DATE OF DEATH APR 20 1995			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14626

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Lulu Belle Wilson</i>				2. DATE OF DEATH MONTH <i>May</i> DAY <i>2</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>8:00 A M</i>	
4. SOCIAL SECURITY NUMBER <i>579-44-7386</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>93</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>6/13/1901</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Rockville Nursing Home</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Rockville, MD</i>		9c. COUNTY OF DEATH <i>Montgomery</i>	
10a. STATE <i>MD</i>		10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Derwood</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>7116 Blanchard Dr.</i>				10f. ZIP CODE <i>20855</i>		10g. CITIZEN OF WHAT COUNTRY? <i>US</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>NO</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: <i>NO</i>		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) <i>8th</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Lab Assistant</i>		15b. KIND OF BUSINESS/INDUSTRY <i>Government</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Joseph Warren Dasher</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Kerren Judy Dasher</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Betty Heflin</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7116 Blanhard Dr., Derwood, Md. 20855</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Mt Olive Lutheran Church 5/5 Peru, WV</i>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Elmore Funeral Home 217 Win Ave. Md WV 26836</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Left Pleural Effusion</i> DUE TO (OR AS A CONSEQUENCE OF): <i>b. Probable malignancy</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c.</i> DUE TO (OR AS A CONSEQUENCE OF): <i>d.</i>							Approximate interval Between Onset and Death <i>2 months</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Longestive Heart Failure</i> <i>Senile Dementia</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29b. SIGNATURE AND TITLE OF CERTIFIER <i>Christopher C. Dunford</i>
29c. LICENSE NUMBER <i>031839</i>				29d. DATE SIGNED (Month, Day, Year) <i>May 5, 1995</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Christopher C. Dunford Rockville, MD 20850</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 11 1995</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14627

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Delphine Arabella Walker</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 18 1995</b>		3. TIME OF DEATH <b>1030</b> M			
4. SOCIAL SECURITY NUMBER <b>210-16-7061</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>August 15, 1922</b>		8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Dorchester General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cambridge</b>			9c. COUNTY OF DEATH <b>Dorchester</b>		
10a. STATE <b>New York</b>				10b. COUNTY <b>Buffalo</b>		10c. CITY, TOWN OR LOCATION <b>Cheektowaga</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>21 Standard Parkway</b>				10f. ZIP CODE <b>14227</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Caucasian</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Shipping Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Food Transport</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Clarence Walter Mallory</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Martha Ann Farling</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Audrey A. Tyler</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>PO Box 591, Bridgeville, Delaware 19933</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Matthew's Cemetery 4/21</b>		20c. LOCATION — City or Town, State <b>W. Seneca, New York</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Moore Funeral Home, P.A. Drawer B, Denton, Maryland 21629</b>					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  a. <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Aspiration pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Neurogenic dysphagia</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Alzheimer's disease</b>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive heart failure</b>								Approximate Interval Between Onset and Death <b>5 days</b> <b>2 weeks</b> <b>2 months</b> <b>5 years</b>	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Rosemary M. Harris</b>		29c. LICENSE NUMBER <b>D-43707</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/18/95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Rosemary M. Harris, M.D. 408 Byrn Street Cambridge, MD 21613</b>									
31. DATE FILED (Month, Day, Year) <b>APR 21 '95</b>		32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14628

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Margaret Salena Wilson				2. DATE OF DEATH MONTH DAY YEAR Apr 28 95		3. TIME OF DEATH 6.00 P M	
4. SOCIAL SECURITY NUMBER 212-18-4453		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept 22 18	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 103 Hamilton Place		9b. CITY, TOWN OR LOCATION OF DEATH Aberdeen	
9c. COUNTY OF DEATH Harford				10a. STATE Maryland		10b. COUNTY Harford	
10c. CITY, TOWN OR LOCATION Aberdeen				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 103 Hamilton Place	
10f. ZIP CODE 21001				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) domestic		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) John Barnes				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Elizabeth White			
19a. INFORMANT'S NAME (Type/Print) Neal Rumsey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 418 Brant Court Havre de Grace, MD 21078			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Clarks United Meth Cem 5-4		20c. LOCATION — City or Town, State Darlington, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Arnold W. Beard Funeral Service 552 Lewis St Havre de Grace, MD 21078			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction Due to (OR AS A CONSEQUENCE OF): b. Due to (OR AS A CONSEQUENCE OF): c. Due to (OR AS A CONSEQUENCE OF): d. Due to (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 4 hrs.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension congestive heart failure							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Nomicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Wilson MD				29c. LICENSE NUMBER D 32609		29d. DATE SIGNED (Month, Day, Year) 5/2/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kamran Mulla MD, 703 Revolution St + Havre De Grace MD 21078							
31. DATE FILED (Month, Day, Year) MAY 03 1995				32. REGISTRAR'S SIGNATURE John Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14629

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>James Francis Wilson, Sr.</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>28</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>10:30 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>079-34-5117</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>51</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 23, 1943</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Physicians Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>La Plata</b>		9c. COUNTY OF DEATH <b>Charles</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Charles</b>		10c. CITY, TOWN OR LOCATION <b>Waldorf</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>6113 Blue Whale Court</b>			
10f. ZIP CODE <b>20603</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Vietnam</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>12</b> College (1-4 or 5+) <b>1</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Owner/Operator</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Night Club</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Charles A. Wilson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anne D. Feddern</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Helen Wilson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11211-A Heron Place, Waldorf, MD 20603</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Maryland Veterans' Cem. 5-3</b>		20c. LOCATION — City or Town, State <b>Cheltenham, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Mark G. Brohawn M00053</b>				22. NAME AND ADDRESS OF FACILITY <b>Huntt Funeral Home P. O. Box 156, Waldorf, MD 20604-0156</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>CARDIAC ARRHYTHMIA / CARDIOPULMONARY ARREST</b>							
b. <b>CORONARY ARTERY DISEASE</b>							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Ramakrishna</b>				29c. LICENSE NUMBER <b>D-16132</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/28/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Nallan Ramakrishna, M.D. 7D Post Office Road, Cenna Center Waldorf, Maryland 20602</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 02 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14630

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) George Miller White				2. DATE OF DEATH MONTH DAY YEAR May 2, 1995				3. TIME OF DEATH 10:30 A M	
4. SOCIAL SECURITY NUMBER 213-05-8157		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 82 YRS.	7. DATE OF BIRTH (Month, Day, Year) Aug. 16, 1912		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) 7797 Patuxent Drive				9b. CITY, TOWN OR LOCATION OF DEATH St. Leonard, MD			9c. COUNTY OF DEATH Calvert		
RESIDENCE OF DECEDENT									
10a. STATE MD		10b. COUNTY Calvert		10c. CITY, TOWN OR LOCATION St. Leonard			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 7797 Patuxent Drive				10f. ZIP CODE 20685		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) farmer			16b. KIND OF BUSINESS/INDUSTRY agriculture		
17. FATHER'S NAME (First, Middle, Last) Clarence E. White				18. MOTHER'S NAME (First, Middle, Maiden Surname) Beatrice Miller					
19a. INFORMANT'S NAME (Type/Print) Judy Rice				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as # 10 above					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Metropolitan Crematory 05/02/95		20c. LOCATION — City or Town, State Alexandria, VA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home, P.A. 4405 Broomes Is. Rd., Port Republic, MD					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>COMPLICATIONS OF ADVANCED ALZHEIMER'S DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death APPROX 3 YRS.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D26358		29d. DATE SIGNED (Month, Day, Year) May 2, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John H. Weigel, M.D. 120 Hospital Rd. Prince Frederick MD20678									
31. DATE FILED (Month, Day, Year) MAY - 3 1995				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14631

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Babybabe Taylor-Young</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 20, 1995</b>		3. TIME OF DEATH <b>12:30 A M</b>	
4. SOCIAL SECURITY NUMBER <b>None</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS <b>2 1</b>		7. DATE OF BIRTH (Month, Day, Year) <b>April 19, 1995</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Holy Cross Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Howard</b>		10c. CITY, TOWN OR LOCATION <b>Columbia</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5611 April Journey</b>				10f. ZIP CODE <b>21044</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (14 or 5+) <b>None</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>None</b>		16b. KIND OF BUSINESS/INDUSTRY <b>None</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Paul A. Young</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Barbara Taylor</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Barbara Taylor-Young</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		DATE <b>4-22</b>		20c. LOCATION — City or Town, State <b>Beltsville, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ellen H. Rapp</b>				22. NAME AND ADDRESS OF FACILITY <b>Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Prematurity</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>b. Premature rupture of membranes</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>c. Chorioamnitis</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death  <b>1 week</b>  <b>1 day</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <b>1</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>C. Taubman, M.D.</b>		29c. LICENSE NUMBER <b>D33198</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 24, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>C. Taubman, M.D.</b>				10801 Lockwood Drive, #290 Silver Spring, MD 20901-1556			
31. DATE FILED (Month, Day, Year) <b>APR 25 1995</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14632

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) DOROTHY ANTOINETTE YOUNGBAR				2. DATE OF DEATH MONTH DAY YEAR APRIL 27, 1995		3. TIME OF DEATH 11:00 AM	
4. SOCIAL SECURITY NUMBER 219-18-7994		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC. 19, 1925	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) 4111 McMULLEN ROAD		9b. CITY, TOWN OR LOCATION OF DEATH TANEYTOWN	
9c. COUNTY OF DEATH CARROLL				10a. STATE MARYLAND		10b. COUNTY CARROLL	
10c. CITY, TOWN OR LOCATION TANEYTOWN				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 3237 HARNEY ROAD	
10f. ZIP CODE 21787				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: CAUCASIAN	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DENTAL ASSISTANT		16b. KIND OF BUSINESS/INDUSTRY DENTAL PRACTICE	
17. FATHER'S NAME (First, Middle, Last) MICHAEL LEWIS SZCZEPANIAK/STEVENS				18. MOTHER'S NAME (First, Middle, Maiden Surname) TINA ANTOINETTE BAK			
19a. INFORMANT'S NAME (Type/Print) JACKIE Y. DIETERICH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4111 McMULLEN ROAD TANEYTOWN, MARYLAND 21787			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SACRED HEART OF JESUS CEM 5/1		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE P. Kevin Judy				22. NAME AND ADDRESS OF FACILITY 136 EAST BALTIMORE STREET SKILES FUNERAL HOME TANEYTOWN, MD 21787			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → BREAST CANCER, METS. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER G. E. M.				29c. LICENSE NUMBER 027730		29d. DATE SIGNED (Month, Day, Year) APRIL 28, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GARY I. COHEN, M.D. 6569 NORTH CHARLES STREET SUITE 205 BALTIMORE, MARYLAND 21204							
31. DATE FILED (Month, Day, Year) APR 28 1995				32. REGISTRAR'S SIGNATURE Julia Dandekar-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Emma Yuhasz</u>				2. DATE OF DEATH MONTH <u>April</u> DAY <u>30</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>8:05 AM</u>	
4. SOCIAL SECURITY NUMBER <u>217-07-1487</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>75</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>AUGUST 29, 1919</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>MERCY HOSPITAL</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>BALTIMORE</u>		9c. COUNTY OF DEATH <u>BALTIMORE CITY</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>MARYLAND</u>		10b. COUNTY <u>BALTIMORE</u>		10c. CITY, TOWN OR LOCATION <u>BALTIMORE</u> COUNTY		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <u>51 HENRY AVENUE</u>				10f. ZIP CODE <u>21236</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>WHITE</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>4</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>ACCOUNTANT</u>		16b. KIND OF BUSINESS/INDUSTRY <u>ACCOUNTING</u>			
17. FATHER'S NAME (First, Middle, Last) <u>GEORGE RICHTER</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>EMMA MEISE</u>			
19a. INFORMANT'S NAME (Type/Print) <u>MICHAEL P. YUHASZ</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>51 HENRY AVENUE BALTIMORE, MARYLAND 21236</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>JERUSALEM LUTHERAN CEMETERY MAY 4, 1995</u>		20c. LOCATION — City or Town, State <u>BALTIMORE, MARYLAND</u>		22. NAME AND ADDRESS OF FACILITY <u>LASSAHN FUNERAL HOME, INC.</u> <u>7401 BELAIR ROAD BALTIMORE, MARYLAND 21236</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Michael Lassahn</u>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Septicemia</u> a. DUE TO (OR AS A CONSEQUENCE OF): <u>Urinary tract Infection</u> b. DUE TO (OR AS A CONSEQUENCE OF): <u>Lymphoma</u> c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Renal failure (oliguria)</u> <u>Gastrointestinal bleeding</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <u>Morris J. Bellon, MD</u> Attending		29c. LICENSE NUMBER <u>007930</u>		29d. DATE SIGNED (Month, Day, Year) <u>April 30, 1995</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <u>MAY 08 1995</u>				32. REGISTRAR'S SIGNATURE <u>Julia Shuster-Rodall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the paper

is devoted to a

discussion of the

main results

of the paper

2. The second part of the paper

is devoted to a

discussion of the

main results

of the paper

3. The third part of the paper

is devoted to a

discussion of the

4. The fourth part of the paper

5. The fifth part of the paper

is devoted to a

discussion of the

main results



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PATRICIA Susan YIPYOUNG				2. DATE OF DEATH MONTH DAY YEAR APRIL 25 95		3. TIME OF DEATH 2:44 P.M.					
4. SOCIAL SECURITY NUMBER 232-74-1145		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 47 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 7, 1947		8. BIRTHPLACE (State or Foreign Country) West Virginia			
9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY			9c. COUNTY OF DEATH PRINCE GEORGES				
10a. STATE Maryland				10b. COUNTY Charles		10c. CITY, TOWN OR LOCATION La Plata		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 110 South Wiltshire Court				10f. ZIP CODE 20646		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Office Manager		16b. KIND OF BUSINESS/INDUSTRY Dental Practice					
17. FATHER'S NAME (First, Middle, Last) Luther Darling Morrison				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jacqueline Dent Hicks Yip-Young							
19a. INFORMANT'S NAME (Type/Print) Dr. Kenneth Yip-Young				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 South Wiltshire Court LaPlata, MD 20646							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Mary's Cemetery		DATE 4/29		20c. LOCATION — City or Town, State Bryantown, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE David C. Cech				22. NAME AND ADDRESS OF FACILITY Arehart-Echols Funeral Home, Inc. P.O. Box 567 La Plata, MD 20646							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Injuries DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 4-25-95		28b. TIME OF INJURY 2:45 P.M.		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED Vehicle (Van) Driven off road struck by alcohol			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Roadway		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Rt 5 La Plata Charles Co MD									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Theresa Breckner MD					29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) APRIL 26, 1995				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Hypatia A. Koron 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) MAY 01 1995				32. REGISTRAR'S SIGNATURE John Davidson-Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14635

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Edna Frances Zurl</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>25</b> YEAR <b>95</b>		3. TIME OF DEATH <b>638 P</b>	
4. SOCIAL SECURITY NUMBER <b>087-16-4936</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 19, 1921</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Carroll County General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Westminster</b>		9c. COUNTY OF DEATH <b>Carroll</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Carroll</b>		10c. CITY, TOWN OR LOCATION <b>Taneytown</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3828 Old Taneytown Road</b>				10f. ZIP CODE <b>21787</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Clerical</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Social Services</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Charles Chesebro</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ann Armrhein</b>			
19a. INFORMANT'S NAME (Type/Print) <b>John J. Zurl</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2405 W. Valley Lane, Silver Run, MD 21158</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Charles Cath. Cemetery 4/29</b>		20c. LOCATION — City or Town, State <b>Farmingdale, NY</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Swann Flaherty Myers</b>				22. NAME AND ADDRESS OF FACILITY <b>Myers Funeral Home 91 Willis Street, Westminster, MD 21157</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiogenic Shock</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Anterior-lateral Myocardial Infarction 11 dys</b> b. _____ c. _____ d. _____						Approximate interval Between Onset and Death <b>140min</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Robert Ricketts MD</b>				29c. LICENSE NUMBER <b>D39296</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/26/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Robert Ricketts MD CCGH Westminster MD 21157</b>							
31. DATE FILED (Month, Day, Year) <b>APR 28 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson Radell</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JORDAN EDWARD AMBROZEWICZ</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 10 95</b>		3. TIME OF DEATH <b>7:10 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>214 39 4791</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>1</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 27, 1993</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9. FACILITY NAME (If not institution, give street and number) <b>UNIVERSITY HOSPITAL</b>		10. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
11. RESIDENCE OF DECEDENT <b>Maryland Anne Arundel</b>				12. COUNTY OF DEATH <b>N.A.</b>		13. CITY, TOWN OR LOCATION OF DEATH <b>Pasadena</b>	
14. STATE <b>Maryland</b>				15. COUNTY <b>Anne Arundel</b>		16. CITY, TOWN OR LOCATION <b>Pasadena</b>	
17. STREET AND NUMBER <b>7706 Queens Park Road</b>				18. ZIP CODE <b>21122</b>		19. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
20. MARITAL STATUS <b>1</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				21. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			
22. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:				23. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
24. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>N.A.</b>				25. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>None</b>			
26. DECEDENT'S USUAL BUSINESS/INDUSTRY <b>NONE</b>				27. FATHER'S NAME (First, Middle, Last) <b>Steven P. Ambrozewicz</b>			
28. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Beverly Campbell</b>				29. INFORMANT'S NAME (Type/Print) <b>Steven P. Ambrozewicz</b>			
30. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7706 Queens Park Road Pasadena, Maryland 21122</b>				31. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			
32. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>				33. DATE <b>5/15</b>		34. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
35. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George J. Gonce</i>				36. NAME AND ADDRESS OF FACILITY <b>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</b>			
37. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Drowning</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death							
38. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
39. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
40. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		41. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)					
42. MANNER OF DEATH <b>1</b> <input type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input checked="" type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>7</b> <input type="checkbox"/> Homicide		43. DATE OF INJURY (Month, Day, Year) <b>5/9/95</b>		44. TIME OF INJURY <b>1830</b> M		45. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO	
46. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify) <b>Home</b>		47. DESCRIBE HOW INJURY OCCURRED <b>Found in a pond unresponsive</b>					
48. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>Pasadena, Md</b>		49. CERTIFIER (Check only one) <b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
50. SIGNATURE AND TITLE OF CERTIFIER <i>Denning Chute</i>				51. LICENSE NUMBER <b>O.C.M.E.</b>		52. DATE SIGNED (Month, Day, Year) <b>MAY 11, 1995</b>	
53. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>111 Penn Street, Baltimore, Maryland 21201</b>							
54. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>				55. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95-2697-047

B.K.S

Item 1 5-12-95 Film G723 W.H.Per F/H

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-724 6/5/95 t.t

95 14637

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOSEPH E. ARGABRIGHT</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 9, 1995</b>		3. TIME OF DEATH <b>11:45 AM</b>	
4. SOCIAL SECURITY NUMBER <b>212-56-3461</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>43</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 12, 1951</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>9 BALTIMORE AVENUE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>OCEAN CITY</b>		9c. COUNTY OF DEATH <b>WORCHESTER</b>	
10a. STATE <b>Md.</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Middle River</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>10 Gladiolus Place</b>				10f. ZIP CODE <b>21220</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Medical Tec</b>		16b. KIND OF BUSINESS/INDUSTRY <b>n/a</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Joseph A. Argabright</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lillian Starling</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Joseph A. Argabright</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10 Gladiolus Place Baltimore MD. 21220</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parkwood Cemetery 5/13/95</b>		20c. LOCATION — City or Town, State <b>Baltimore Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>R. Terry Connelly</b>				22. NAME AND ADDRESS OF FACILITY <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ALCOHOL AND BUTALBITAL INTOXICATION</b>							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>MOTEL</b>					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input checked="" type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>UNKNOWN</b>		28b. TIME OF INJURY <b>UNKNOWN</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED <b>SUBJECT INGESTED ALCOHOL AND DRUGS</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>UNKNOWN</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>UNKNOWN</b>			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Mario F. Gonzalez</b>				29c. LICENSE NUMBER <b>O.C.M.E</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 10, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GONZALEZ JR. 11 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED <b>MAY 12 1995</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14638

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LOUIS BOWIE</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>06</b> YEAR <b>95</b>		3. TIME OF DEATH <b>6:35 AM</b>	
4. SOCIAL SECURITY NUMBER <b>218-18-8084</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 14, 1925</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>St. Agnes Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>234 B Stonecroft Rd.</b>			
10f. ZIP CODE <b>21229</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>3</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Minister</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Ministry</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Bert Bowie</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Catherine Cromwell</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Edna Bowie</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>234 B Stonecroft Rd. Balto. Md. 21229</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Meadowridge 5/10/95</b>		20c. LOCATION — City or Town, State <b>Elkridge, Md</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Joseph L. Russ</b>				22. NAME AND ADDRESS OF FACILITY <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b>							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
a. DUE TO (OR AS A CONSEQUENCE OF): <b>Urinary Tract Infection</b>							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Antoine Arkieh (Medical Resident)</b>				29c. LICENSE NUMBER <b>046599</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 11, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ANTOINE ARKIEH St. Agnes Hosp 900 Caton Ave</b>							
31. DATE SIGNED (Month, Day, Year) <b>MAY 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>John A. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



B.K.S.  
95-2721-510

95 14639

FilmG, 723, item #20b, 5/12/95, cyw, per f.h.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) KENNETH JASON BOYKIN				2. DATE OF DEATH MONTH DAY YEAR MAY 10, 1995				3. TIME OF DEATH 11:41 A M	
4. SOCIAL SECURITY NUMBER unknown		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 32 YRS.		7. DATE OF BIRTH MONTH DAY YEAR MAY 20, 1962		8. BIRTHPLACE (State or Foreign Country) BALTIMORE, MD	
9a. FACILITY NAME (If not institution, give street and number) GOOD SAMARITAN HOSPITAL E.R.				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH n/a	
10a. STATE MARYLAND				10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 1819 WADSWORTH WAY				10f. ZIP CODE 21239	
10g. CITIZEN OF WHAT COUNTRY? UNITED STATES				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: BLACK				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TR College (1-4 or 5+) -	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DRIVER/ MANAGER				16b. KIND OF BUSINESS/INDUSTRY TRANSPORTATION CO. INC.				17. FATHER'S NAME (First, Middle, Last) JOSEPH THOMAS BOYKIN	
18. MOTHER'S NAME (First, Middle, Maiden Surname) GEORGETTE WHITE				19a. INFORMANT'S NAME (Type/Print) GEORGETTE BOYKIN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 937 N. CENTRAL AVENUE, BALTIMORE, MD 21202	
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEMETERY 5-15				20c. LOCATION — City or Town, State BALTIMORE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Asthma DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E.	
29d. DATE SIGNED (Month, Day, Year) MAY 11, 1995				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201				31. DATE FILED (Month, Day, Year) MAY 12, 1995	
32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

15

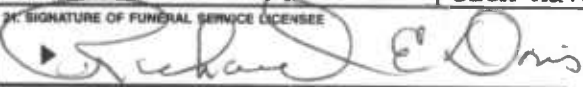


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14640

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RUTH MAE BONNER</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>9</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>7:15P M</b>				
4. SOCIAL SECURITY NUMBER <b>219 32 2151</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 18, 1906</b>		8. BIRTHPLACE (State or Foreign Country) <b>West Virginia</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Harbor Hospital Center</b>					9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH <b>N.A.</b>			
RESIDENCE OF DECEDENT												
10a. STATE <b>Maryland</b>			10b. COUNTY <b>Anne Arundel</b>			10c. CITY, TOWN OR LOCATION <b>Baltimore</b>			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>5337 Wasena Avenue</b>						10f. ZIP CODE <b>21225</b>			10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Home Maker</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>				
17. FATHER'S NAME (First, Middle, Last) <b>Jacob Montoney</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ella Lambert</b>						
19a. INFORMANT'S NAME (Type/Print) <b>Forrest M. Bonner</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1210 Hoffman Home Rd. Littlestown, Pennsylvania 17340</b>						
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Glen Haven Memorial Park 5/13</b>				20c. LOCATION — City or Town, State <b>Glen Burnie, Maryland</b>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY <b>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</b>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CONGESTIVE HEART FAILURE</b>										Approximate Interval Between Onset and Death <b>15 DAYS</b>		
DUE TO (OR AS A CONSEQUENCE OF): <b>HYPERTENSION ASTHMA</b>										<b>5 YEARS</b>		
DUE TO (OR AS A CONSEQUENCE OF): <b>ANGINA DIABETES MELITUS</b>										<b>10 YEARS</b>		
DUE TO (OR AS A CONSEQUENCE OF): <b>IRON DEFICIENCY ANEMIA</b>										<b>3 YEARS</b>		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER <b>AS244161436</b>			29d. DATE SIGNED (Month, Day, Year) <b>MAX 9, 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>NAVTEJ SINGH BUTTAR 3001 SOUTH HANOVER STREET BALTIMORE MD.</b>												
31. DATE FILED (Month, Day, Year) <b>MAY 1 2 1995</b>				32. REGISTRAR'S SIGNATURE 								

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14641

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARGARET BURKE</b>				2. DATE OF DEATH MONTH <b>5</b> DAY <b>9</b> YEAR <b>95</b>		3. TIME OF DEATH <b>1:50 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>214-36-9901</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 6, 1908</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>IVY HALL GERIATRIC CTR</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTO</b>	
9c. COUNTY OF DEATH <b>BALTO</b>				10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>6408 Alt Ave.</b>	
10f. ZIP CODE <b>21206</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>8th</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Central Supply</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Union Memorial Hospital</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Michael Leonard</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Cecelia Kelly</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Theresa Farren</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6408 Alt Ave. Baltimore Md. 21206</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holy Redeemer Cemetery</b>		20c. LOCATION — City or Town, State <b>5/12/95 Baltimore Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>R. Terry Connelly</b>				22. NAME AND ADDRESS OF FACILITY <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>organic brain sd.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>chronic urinary infection</b> c. <b>Dehydration</b> d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>osteoarthritis, chronic</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature] M.D.</b>		29c. LICENSE NUMBER <b>D15414</b>	
29d. DATE SIGNED (Month, Day, Year) <b>5/11/95</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>6331 Belair Rd. Baltimore MD 21206</b>			
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14642

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOHN BLIZZARD SR.</b>				2. DATE OF DEATH MONTH <b>5</b> DAY <b>8</b> YEAR <b>95</b>		3. TIME OF DEATH <b>9:27 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>235-01-1480</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 1, 1912</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>IVY HALL GERIATRIC CTR.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTO</b>		9c. COUNTY OF DEATH <b>BALTO</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>White Marsh</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5611 Allender Road</b>				10f. ZIP CODE <b>21162</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Lithographer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>n/a</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Fredrick C. Blizzard</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Leona Miller</b>			
19a. INFORMANT'S NAME (Type/Print) <b>James Howdyshe11</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5611 Allender Road White Marsh Md. 21162</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gardens of Faith 5/12/95</b>		20c. LOCATION — City or Town, State <b>Rossville Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>R. Terry Connelly</b>				22. NAME AND ADDRESS OF FACILITY <b>Connelly Funeral Home of Essex 300 Maco Ave. Baltimore Md. 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Possible Acute MI &amp; Pulmonary Edema</b>							
DUE TO (OR AS A CONSEQUENCE OF): <b>Ascho</b>							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF): <b>Cancer of Colon &amp; rect</b>							
DUE TO (OR AS A CONSEQUENCE OF): <b>Dementia</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>D14221</b>		29d. DATE SIGNED (Month, Day, Year) <b>5.9.95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Tarique Firozvi 223 Eastern Ave. Baltimore MD. 21221</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14643

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Sue BARNES				2. DATE OF DEATH MONTH DAY YEAR May 10 1995		3. TIME OF DEATH 12:47 P M	
4. SOCIAL SECURITY NUMBER 196-18-0444		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 82 YRS.	7. DATE OF BIRTH (Month, Day, Year) Oct. 28, 1912		8. BIRTHPLACE (State or Foreign Country) PA.	
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rossville		9c. COUNTY OF DEATH Baltimore	
10a. STATE Md.				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Essex	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 613 Delaware Ave.		10f. ZIP CODE 21221	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) Cafateria Supervisor	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cafateria Supervisor				16b. KIND OF BUSINESS/INDUSTRY Martin's		17. FATHER'S NAME (First, Middle, Last) Joseph Drotar	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine Rebovich				19a. INFORMANT'S NAME (Type/Print) Catherine Ewell		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 613 Delaware Ave. Baltimore Md. 21221	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 5/12/95		20c. LOCATION — City or Town, State Baltimore Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE K. Terry Connelly				22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Massive cerebrovascular accident DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerotic cerebrovascular disease DUE TO (OR AS A CONSEQUENCE OF): c. Hypertension DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death 40 minutes 3 years 10 years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER H.D.		29c. LICENSE NUMBER D42083		29d. DATE SIGNED (Month, Day, Year) May 10, 1995		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) G.A. Wheeler, H.D. FSNC, ER 9000 Franklin Square Drive, BALTIMORE MD	
31. DATE FILED (Month, Day, Year) MAY 12 1995		32. REGISTRAR'S SIGNATURE John Anderson					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14644

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ANNIE BUNCH</b>				2. DATE OF DEATH MONTH DAY YEAR <b>4 26 95</b>		3. TIME OF DEATH <b>11:52 P M</b>	
4. SOCIAL SECURITY NUMBER <b>243-01-4647</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 24, 1913</b>	
8. BIRTHPLACE (State or Foreign Country) <b>North Carolina</b>				9. FACILITY NAME (If not institution, give street and number) <b>LIVINGSTON HEALTH CARE CENTER</b>		10. CITY, TOWN OR LOCATION OF DEATH <b>FORT WASHINGTON</b>	
11. RESIDENCE OF DECEDENT 10a. STATE <b>Maryland</b>				10b. COUNTY <b>Prince Georges'</b>		10c. CITY, TOWN OR LOCATION <b>Fort Washington</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>308 Riverband Road</b>		10f. ZIP CODE <b>20744</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3rd.</b> College (1-4 or 5+) <b>Homemaker</b>	
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>		17. FATHER'S NAME (First, Middle, Last) <b>Unobtainable</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Unobtainable</b>				19a. INFORMANT'S NAME (Type/Print) <b>Brenda Carroll-Mitchell/niece</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>308 Riverband Rd. Ft. Wash., Md. 20744</b>	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Washington National Cemetery</b> <b>5/1/95</b>		20c. LOCATION — City or Town, State <b>Suitland, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert G. Mason</i> #866				22. NAME AND ADDRESS OF FACILITY <b>Robert G. Mason Funeral Home, Inc.</b> <b>1661 Good Hope Road, S.E. Wash., DC 20020</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acute Fatal Cardiac Arrhythmia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>2 mins.</b> <b>b. Underlying Coronary Artery Disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>20 yrs.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Congestive Heart Failure, High Blood Pressure, Intraeranian Bleeding, Stroke, Dysphagia</b> <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard G. Farnson MD</i>				29c. LICENSE NUMBER <b>D02237MD</b>		29d. DATE SIGNED (Month, Day, Year) <b>04/26/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Richard A. Farnson, MD 12825 Old Fort Road Fort Wash., Md. 20744</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 8 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95-2681-510  
ML

95 14645

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOHN M. BARTRAM</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 08 1995</b>		3. TIME OF DEATH <b>9:50 A<sup>M</sup></b>	
4. SOCIAL SECURITY NUMBER <b>219-82-3602</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>30 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>09/28/64</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1024 N. MILTON AVENUE</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>250 S. Castle Street</b>	
10f. ZIP CODE <b>21231</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1982 - 1985</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (1-4 or 5+) <b>Cook</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Cook</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Restaurant</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Stanley F. Bartram</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dorothy V. Lanier</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Charmaine Bartram</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>250 S. Castle Street Baltimore, Md. 21231</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Carmel Cemetery 5/11</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David J. Weber</i>				22. NAME AND ADDRESS OF FACILITY <b>David J. Weber Funeral Home 21231 401 S. Chester Street Balto. Md.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>HANGING</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>VACANT BUILDING</b>			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>5/8/95 FOUND</b>		28b. TIME OF INJURY <b>0900A M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT HANGED SELF</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>BUILDING</b>	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>1024 N. MILTON AVE BALTIMORE MD</b>				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mario F. Golis Jr MD</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 09, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GOLIS JR MD 111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			





95 14646

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Bernice Oliver Booth</u>				2. DATE OF DEATH MONTH <u>May</u> DAY <u>7</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>11:30 A M</u>	
4. SOCIAL SECURITY NUMBER <u>227-62-3900</u>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <u>82</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>12/10/12</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Virginia</u>				9a. FACILITY NAME (If not institution, give street and number) <u>Liberty Medical Center</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>	
9c. COUNTY OF DEATH <u>N/A</u>				10a. STATE <u>Maryland</u>		10b. COUNTY <u>N/A</u>	
10c. CITY, TOWN OR LOCATION <u>Baltimore</u>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>2103 Windsor Avenue</u>	
10f. ZIP CODE <u>21217</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6th</u> College (1-4 or 5+) <u></u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Housewife</u>		16b. KIND OF BUSINESS/INDUSTRY <u>In House</u>	
17. FATHER'S NAME (First, Middle, Last) <u>WESLEY OLIVER</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>MARTHA WARD</u>			
19a. INFORMANT'S NAME (Type/Print) <u>BARBARA CASEY</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3512 Spaulding Avenue Balto., MD 21215</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Garrison Forest Vet. Cem. 5/11</u>		20c. LOCATION — City or Town, State <u>Owings Mills, MD</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Leroy O. Dyett</u>				22. NAME AND ADDRESS OF FACILITY <u>LEROY O. DYETT &amp; SON FUNERAL HOME</u> <u>4600 Liberty Heights avenue 21207</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Cardiac arrest</u> Approximate Interval Between Onset and Death <u>2 days</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <u>Respiratory failure</u> <u>10 days</u> <u>Intraabdominal sepsis</u> <u>21 days</u> <u>Enterocutaneous fistula</u>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <u>Leroy O. Dyett, M.D.</u>	
29c. LICENSE NUMBER <u>D24355</u>				29d. DATE SIGNED (Month, Day, Year) <u>5/8/95</u>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Leroy S. Dingle, M.D., 301 St. Paul Place Suite 815 Balto, MD 21202</u>	
31. DATE FILED (Month, Day, Year) <u>MAY 12 1995</u>				32. REGISTRAR'S SIGNATURE <u>Jane Anderson</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14647

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Mykele Brown</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>28</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>4:12 a m</b>	
4. SOCIAL SECURITY NUMBER <b>217-13-6052</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>11</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11/13/83</b>	
8. FACILITY NAME (If not institution, give street and number) <b>Mt. Washington Pediatric Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>7/A</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>7/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5808 Gwynn Oak Avenue</b>				10f. ZIP CODE <b>21207</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2nd</b> College (1-4 or 5+) <b>Child</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Child</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Not applicable</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Michael Brown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Annie Brown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Annie Brown</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5808 Gwynn Oak Ave., Baltimore, Md. 21207</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 4/28/95</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md.</b>		22. NAME AND ADDRESS OF FACILITY <b>JOSEPH H. BROWN, JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD 21223</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>JOSEPH H. BROWN, JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD 21223</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acute Renal Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Hemolytic Uremic Syndrome</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. _____</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. _____</b> Approximate interval Between Onset and Death <b>1 month</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>chromosomal mosaicism, severe cerebral palsy, mental retardation</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D45401</b>		29d. DATE SIGNED (Month, Day, Year) <b>04/30/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type Print) <b>John N. Schuen, MD; 4913 Berryhill Circle, Perry Hall, Md. 21128</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO

1911

1911

MAILED 1911

95 14648

FilmG, 723, item #4, 10e,11,12,16a, 5/12/95, cyw, per f.h.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CLAYTON R. COLEMAN</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>07</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>12:50 P M</b>	
4. SOCIAL SECURITY NUMBER <b>220-03-99255 A</b>		5. SEX <b>1</b> M <b>2</b> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT. 12, 1907 S.</b>	
8. BIRTHPLACE (State or Foreign Country) <b>CAROLINA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>BON SECOUR HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH <b>n/a</b>				10a. STATE <b>MARYLAND</b>			
10b. COUNTY <b>n/a</b>				10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>			
10d. INSIDE CITY LIMITS? <b>X</b> YES <b>2</b> NO				10e. STREET AND NUMBER <b>1610 W. LAFAYETTE STREET AVENUE</b>			
10f. ZIP CODE <b>21217</b>				10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
11. MARITAL STATUS <b>X</b> Never Married <b>2</b> Married <b>X</b> Widowed <b>4</b> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO IF YES, GIVE WAR OR DATES <b>ARMY</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> YES <b>2</b> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5 TH</b> College (1-4 or 5+) <b>-</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MERCHANT SEAMON</b>		16b. KIND OF BUSINESS/INDUSTRY <b>STEAMSHIP TRADE</b>	
17. FATHER'S NAME (First, Middle, Last) <b>CLAYTON COLEMAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ISABELLE BURNSIDE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>HELEN MATTHEWS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1610 W. LAFAYETTE AVENUE, BALTIMORE, MD 21217</b>			
20a. METHOD OF DISPOSITION <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>8</b> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARRISON FOREST VA CEMETERY</b>		20c. LOCATION — City or Town, State <b>5-12 OWINGS MILLS, MD</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert E. Prince</i>				22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FH.-1101 E. NORTH AE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>bronchogenic carcinoma</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>metastasis</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>no code</b>							
24a. WAS AN AUTOPSY PERFORMED? <b>1</b> YES <b>2</b> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> YES <b>2</b> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> YES <b>2</b> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA OTHER: <b>4</b> Nursing Home <b>5</b> Residence <b>8</b> Other (Specify)			
27. MANNER OF DEATH <b>1</b> Natural <b>5</b> Pending Investigation <b>2</b> Accident <b>3</b> Suicide <b>8</b> Could not be determined <b>4</b> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <b>1</b> YES <b>2</b> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Elmo Gayoso, M.D.</i>				29c. LICENSE NUMBER <b>Q-14528</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/9/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ELMO GAYOSO, M.D. 5411 Old Frederick Road Balto MD 21229</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Item 6 5-12-95 Film G723 W.H. Per F/H  
ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-723 5/23/95 t.t

95 14649

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY N. CAPERS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 09 95</b>		3. TIME OF DEATH <b>5:05 PM</b>					
4. SOCIAL SECURITY NUMBER <b>214-82-2064</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>32</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6-1-62</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>BON SECOURS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>				9c. COUNTY OF DEATH <b>n/a</b>			
10a. STATE <b>MD</b>		10b. COUNTY <b>n/a</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>1832 Laurens St.</b>				10f. ZIP CODE <b>21217</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Assembly Personn</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Advertising</b>							
17. FATHER'S NAME (First, Middle, Last) <b>William Watkins, Jr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Carol Capers</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Carol Capers</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1609 Lorman Ct. Balto., MD 21217</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>King Memorial Park 5/16</b>		20c. LOCATION — City or Town, State <b>Balto., Md.</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James A. Morton</i>				22. NAME AND ADDRESS OF FACILITY <b>James A. Morton &amp; Sons Funeral Homes 1701 Laurens St. Balto., MD 21217</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>NARCOTIC INTOXICATION</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.  Approximate Interval Between Onset and Death											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>UNKNOWN</b>		28b. TIME OF INJURY <b>UNKNOWN</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT INJECTED DRUGS</b>			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>UNKNOWN</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>UNKNOWN</b>					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. SIGNATURE AND TITLE OF CERTIFIER <i>John A. Morton</i> 29c. LICENSE NUMBER <b>O.C.M.E.</b> 29d. DATE SIGNED (Month, Day, Year) <b>MAY 10, 1995</b>											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) <b>MARK P. GIBBS JR. 111 Penn Street, Baltimore, Maryland 21201</b>											
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>		32. REGISTRAR'S SIGNATURE <i>John A. Morton</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14650

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Frances P. Cohen				2. DATE OF DEATH MONTH DAY YEAR May 5, 1995		3. TIME OF DEATH 1:30 A. M	
4. SOCIAL SECURITY NUMBER 057-22-7492		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 26, 1907	
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Bethesda		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 6551 Wiscasset Road				10f. ZIP CODE 20816		10g. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 Years		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) School Teacher		15b. KIND OF BUSINESS/INDUSTRY New York Public Schools			
17. FATHER'S NAME (First, Middle, Last) Morris Pakett				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Sagett			
19a. INFORMANT'S NAME (Type/Print) Peter Cohen				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6551 Wiscasset Road, Bethesda, Maryland 20816			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesapeake Crematory 5/7/1995		20c. LOCATION — City or Town, State Beltsville, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald C. Stottmeyer				22. NAME AND ADDRESS OF FACILITY STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, N.W., WASHINGTON, D.C.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		Sepsis				Approximate Interval Between Onset and Death 48°	
		Dehydration				72°	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		Cronh's Colitis				yrs.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER John Shumacher MD				29c. LICENSE NUMBER D41931		29d. DATE SIGNED (Month, Day, Year) May 5, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R Shumacher MD 2309 Shorefield Rd Wheaton, MD 20902							
31. DATE FILED (Month, Day, Year) MAY 12 1995		32. REGISTRAR'S SIGNATURE John Shumacher					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14651

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DAISY CHRISTINE DANIEL</b>				2. DATE OF DEATH MONTH <b>5</b> DAY <b>8</b> YEAR <b>95</b>		3. TIME OF DEATH <b>01:01A</b>	
4. SOCIAL SECURITY NUMBER <b>213-34-8068</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs., last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 28, 1915</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Good Samaritan Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1090 Cameron Rd.</b>		10f. ZIP CODE <b>21212</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+) <b>0</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William Morgan</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lovella Patterson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Georgianna Little</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2607 Robb St. Balto. Md. 21218</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>Garrison Forest 5/12/95</b>		20c. LOCATION — City or Town, State <b>Owings Mills, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Joseph L. Russ</b>				22. NAME AND ADDRESS OF FACILITY <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. cardiac arrest</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. end-stage cardiomyopathy</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal Failure</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>A. J. Amey M.D.</b>				29c. LICENSE NUMBER <b>D-47014</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/8/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>6724 Bonnie Ridge T-2, Balto 21209 JANECKI</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b> 5 <b>John H. Harkell</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14652

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>William Bowen Davis</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>10</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>3:00 PM</b>	
4. SOCIAL SECURITY NUMBER <b>217-01-6158</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan 17, 1919</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Bayview Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>n/a</b>	
10a. STATE <b>Md.</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>491 Mirabile Lane</b>				10f. ZIP CODE <b>21224</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Self-employed</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Coal Business</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Milton M. Davis</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Reggie Bowen</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Marrie Davis</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>491 Mirabile Lane Baltimore Md. 21224</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory Inc, 5/11/95 Baltimore Md.</b>		20c. LOCATION — City or Town, State <b>Baltimore Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>R. Terry Connelly</b>				22. NAME AND ADDRESS OF FACILITY <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Coronary Artery Disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <b>MIN</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive Heart Failure, COPD</b> <b>Acute Myocardial infarction 10 days prior to death</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Carl Sperling</b>		29c. LICENSE NUMBER <b>D28987</b>		29d. DATE SIGNED (Month, Day, Year) <b>5-11-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>CARL SPERLING, MD, 5601 LOCH RAVEN BLVD BALTO. MD 21239</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>		32. REGISTRAR'S SIGNATURE <b>Alii</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14653

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Dorothy Everhart</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>7</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>5:20 p</b> <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>212-22-5959</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 22, 1917</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>		9a. FACILITY NAME (If not institution, give street and number) <b>John Hopkins - Bayview</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>n/c</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>n/a</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1002 Quantril Way</b>				10f. ZIP CODE <b>21205</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b>n/a</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Sales Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Retail</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Cook</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Pfawr</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Paul Everhart Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1002 Quantril Way Baltimore Md. 21205</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holly Hill Cemetery 5/11/95 Baltimore Md.</b>		20c. LOCATION — City or Town, State		20d. DATE <b>5/11/95</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>R. Terry Connelly</b>				22. NAME AND ADDRESS OF FACILITY <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD. 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute closed head injury - Subdural hematoma</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Due to (OR AS A CONSEQUENCE OF):</b> b. <b>Due to (OR AS A CONSEQUENCE OF):</b> c. <b>Due to (OR AS A CONSEQUENCE OF):</b> d.						Approximate Interval Between Onset and Death <b>hours</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>MAY 7, 1995</b>		28b. TIME OF INJURY <b>5:20 A M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>Patient fell down stairs.</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>HOME</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>1002 QUANTRIL WAY BALTIMORE MD</b>			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>John R. Doty MD</b>				29c. LICENSE NUMBER <b>MSIBS J-H.H.</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 7, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOHN R. DOTY, MD DEPT OF SURGERY, JOHNS HOPKINS BAYVIEW MED CTR.</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>John R. Doty</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14654

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Rae Friedman</b>				2. DATE OF DEATH MONTH <b>5</b> DAY <b>3</b> YEAR <b>95</b>		3. TIME OF DEATH <b>2:15 P M</b>	
4. SOCIAL SECURITY NUMBER <b>577-54-1305D</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>91</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 25, 1903</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Washington, DC</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Hebrew Home Of Greater Washington</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>D.C.</b>		10b. COUNTY <b>None</b>	
10c. CITY, TOWN OR LOCATION <b>Washington</b>				10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>		10e. STREET AND NUMBER <b>3001 Veazey Terrace, N.W., Apt. #1612</b>	
10f. ZIP CODE <b>20008</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b> Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12 Yrs</b>			
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Aba Kerschbaum</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ida Gold</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Larry Green</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7035 Woodstream Terrace, Seabrook, MD 20706-2154</b>			
20a. METHOD OF DISPOSITION <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mount Lebanon Cemetery 5/05/1995</b>			
20c. LOCATION — City or Town, State <b>Adelphi, MD</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Donald C. Stottmeyer</b>			
22. NAME AND ADDRESS OF FACILITY <b>STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL ST, NW, WASHINGTON, DC 20012</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PANCREATIC CANCER</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>3 Weeks</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>				26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>			
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>				28a. DATE OF INJURY (Month, Day, Year) <b>5/3/95</b>			
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? <b>1 YES 2 NO</b>			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Burt I. Feldman</b>				29c. LICENSE NUMBER <b>D 23958</b>			
29d. DATE SIGNED (Month, Day, Year) <b>5/3/95</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Burt I. Feldman, 6121 Montrose Rd, Rockville MD 20852</b>			
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>John A. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KARON KOREN GROSS</b>		2. DATE OF DEATH <b>May 10, 1995</b>		3. TIME OF DEATH <b>1:45 A M</b>	
4. SOCIAL SECURITY NUMBER <b>214-62-5671</b>		5. SEX <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>		6. AGE (In yrs. last birthday) <b>44</b> YRS.	
7a. FACILITY NAME (If not Institution, give street and number) <b>Levindale Nursing Center</b>		7b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		7c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>MD.</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>		10e. STREET AND NUMBER <b>2 Mount Batten Court</b>		10f. ZIP CODE <b>21207</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		11. MARITAL STATUS <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b> IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12th</b> <b>College (14 or 5+) 2</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Data Entry Processing</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Internal Revenue</b>		17. FATHER'S NAME (First, Middle, Last) <b>Thomas M. Gross</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Katherine Satterfield</b>		19a. INFORMANT'S NAME (Type/Print) <b>Katherine Gross</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2 Mount Batten Court Balto., MD. 21217</b>	
20a. METHOD OF DISPOSITION <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus Memorial Pk. 2/95</b>		20c. LOCATION — City or Town, State <b>Arbutus, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Doretha Hecton</b>		22. NAME AND ADDRESS OF FACILITY <b>CFSP #281 E.L. Phillips F/H 1721-27 N. Monroe St Balto., MD. 21217</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sudden Cardiac death</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Pulmonary sarcoid</b> <b>Neurosarcoid</b> <b>Anoxic Encephalopathy</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>		26. PLACE OF DEATH (Check only one) <b>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>	
27. MANNER OF DEATH <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>		28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <b>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>	
29c. LICENSE NUMBER <b>D35685</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/11/95</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SALAZRAGA Hoffberger 22 Swan Hosp 2120</b>	
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14656

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) OWEN A. GARNER JR.				2. DATE OF DEATH MONTH DAY YEAR MAY 09 95		3. TIME OF DEATH 5:20 P.M.	
4. SOCIAL SECURITY NUMBER 216-50-8290		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 46 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT 28, 1948	
8. BIRTHPLACE (State or Foreign Country) MD				9a. FACILITY NAME (If not institution, give street and number) SHIPYARD AT SPARROWS POINT		9b. CITY, TOWN OR LOCATION OF DEATH SPARROWS POINT	
9c. COUNTY OF DEATH BALTIMORE				10a. STATE MD		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION BALTO				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 811 N. BENTALOU ST.	
10f. ZIP CODE 21216				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: BLACK				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12TH N/A			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SHIPFITTER				16b. KIND OF BUSINESS/INDUSTRY BETHELEHEM STEEL			
17. FATHER'S NAME (First, Middle, Last) OWEN ALEXANDER GARNER				18. MOTHER'S NAME (First, Middle, Maiden Surname) CLARA BLAKE			
19a. INFORMANT'S NAME (Type/Print) BARBARA GARNER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 811 N. BENTALOU ST. BALTO, MD 21216			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL PARK 51595			
20c. LOCATION — City or Town, State RANDALLSTOWN, MD				21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			
22. NAME AND ADDRESS OF FACILITY MARCH F/H-WEST 4300 WABASH AVE				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SMOKE INHALATION DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Not determined				28a. DATE OF INJURY (Month, Day, Year) 5/9/95			
28b. TIME OF INJURY 1445 P.M.				28c. INJURY AT WORK? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED FIRE ON BOARD SHIP				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) SHIP			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) SPARROW'S PT. SHIPYARD, BALTIMORE (MD)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E.			
29d. DATE SIGNED (Month, Day, Year) MAY 10, 1995				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GONZALEZ JR. 111 Penn Street, Baltimore, Maryland 21201			
31. DATE FILED (Month, Day, Year) MAY 12 1995				32. REGISTRAR'S SIGNATURE 			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14657

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lloyd Lonsdale Goodman				2. DATE OF DEATH MONTH DAY YEAR May 4, 1995		3. TIME OF DEATH 11:00A M			
4. SOCIAL SECURITY NUMBER 218-07-7005		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 82 YRS.	7. DATE OF BIRTH (Month, Day, Year) Jan. 5, 1913		8. BIRTHPLACE (State or Foreign Country) Norfolk, VA.			
9a. FACILITY NAME (If not institution, give street and number) 11203 Beach Road				9b. CITY, TOWN OR LOCATION OF DEATH White Marsh		9c. COUNTY OF DEATH Baltimore			
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION White Marsh		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 11203 Beach Road				10f. ZIP CODE 21162		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Building Contractor		16b. KIND OF BUSINESS/INDUSTRY Self-Employed					
17. FATHER'S NAME (First, Middle, Last) Lloyd L. Goodman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lotta (unknown)					
19a. INFORMANT'S NAME (Type/Print) Jerry O'Neal				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11204 Beach Road White Marsh, Md. 21162					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lake View Cemetery May 8, 1995		20c. LOCATION — City or Town, State Baltimore, Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>E. F. Lassahn</i>				22. NAME AND ADDRESS OF FACILITY E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, Md. 21087					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Emphysema</i>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Martin Sheridan</i>				29c. LICENSE NUMBER D21846		29d. DATE SIGNED (Month, Day, Year) 5/5/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Martin Sheridan-Franklin Sq. Hosp. 687-6622									
31. DATE FILED (Month, Day, Year) MAY 12 1995				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14658

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Claire Greidinger				2. DATE OF DEATH MONTH DAY YEAR May 1, 1995		3. TIME OF DEATH 4:30 p M	
4. SOCIAL SECURITY NUMBER 112 36 5867		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 21, 1905	
9. FACILITY NAME (If not institution, give street and number) Meridian Health Care Center At Aspenwood				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3227 Bel Pre Road				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Louis Raab				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Trager			
19a. INFORMANT'S NAME (Type/Print) Rhonda Greenberg				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 53 Portside Court Gaithersburg, MD 20877			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Beth David Cemetery 5/4/95		20c. LOCATION — City or Town, State Elmont, New York			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ives-Pearson Funeral Homes Falls Church, VA 22046			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Chronic illness DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER Do 2338		29d. DATE SIGNED (Month, Day, Year) 5.2.1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RICHARD P. DELANEY, M.D. 9801 GEORGIA AVE. SILVER SPRING, MD. 20902							
31. DATE FILED (Month, Day, Year) MAY 12 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14659

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Charles GRANT</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 10, 1995</b>		3. TIME OF DEATH <b>4:06 P M</b>	
4. SOCIAL SECURITY NUMBER <b>233-38-2269</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-4-1926</b>	
8. BIRTHPLACE (State or Foreign Country) <b>W. Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Rosedale</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Middle River</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1523 Aldney Ave</b>	
10f. ZIP CODE <b>21220</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>12/46 - 7/47</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>			
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Steelworker</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Beth-Steel</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Delbert H. Grant</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Alice Reffett</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Carma Jean Red</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1523 Aldney Ave Baltimore, Md 21220</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cem. Mt. Zion Methodist 5-13</b>			
20c. LOCATION — City or Town, State <b>Bel Air, Md.</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Anthony Colt Connelly</b>			
22. NAME AND ADDRESS OF FACILITY <b>Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arrhythmia</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> b. <b>Arteriosclerotic cardiovascular disease</b> c. <b>15minutes</b> d. <b>10years</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>28b. TIME OF INJURY M</b> <b>28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</b> <b>28d. DESCRIBE NOW INJURY OCCURRED</b> <b>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)</b> <b>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)</b>			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Laurie Harris</b>			
29c. LICENSE NUMBER <b>D 26116</b>				29d. DATE SIGNED (Month, Day, Year) <b>5/10/95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Laurie Harris 9000 Franklin Square Dr. Baltimore, Maryland 21237</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Anderson</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

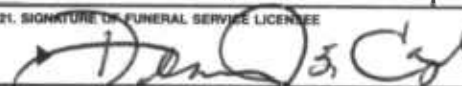



asp

95 14660

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>TIMOTHY M. HAMILTON Jr.</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>07</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>3:55 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>575-39-5486</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>20</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec 21, 1974</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Germany</b>				9a. FACILITY NAME (If not Institution, give street and number) <b>ST. LO DRIVE</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH				10a. STATE <b>Maryland</b>			
10b. COUNTY				10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>710 E. 37th Street</b>			
10f. ZIP CODE <b>21218</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Driver</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Balto City Gov't</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Timothy M. Hamilton Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Monica Lisa Frazier</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Alfia L. Hamilton</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>710 E. 37th Street Baltimore, Md. 21218</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Wilson Mem Meth Cem 5/10/95 Gambrill, Md.</b>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Caple Funeral Service 5502 Winner Avenue Balto, Md. 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Head and neck injuries</b> DUE TO (OR AS A CONSEQUENCE OF): Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>5/7/95</b>		28b. TIME OF INJURY <b>0346 M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>DRIVER, LOST CONTROL OF AUTO</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>STREET</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>ST LO DRIVE AT SA. CLAIR LANE</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Donald G. Wright MD</b>				29c. LICENSE NUMBER <b>O.C.M.E</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 07, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14661

1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Ben Harding</i>				2. DATE OF DEATH MONTH <i>May</i> DAY <i>7</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>8:45A</i> M	
4. SOCIAL SECURITY NUMBER <i>217-30-3585</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>60</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>December 10, 1934</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>830 Harlem Ave</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH <i>NA</i>	
10a. STATE <i>MD</i>				10b. COUNTY <i>NA</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <i>830 Harlem Ave</i>				10f. ZIP CODE <i>21201</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>5th grade</i> College (1-4 or 5+) <i>NA</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Truck Driver</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Farm</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Banks Harding</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Queen Cook</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mary L. Hudson</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3438 Piedmont Ave</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Western Star Cem</i> DATE <i>5/9/95</i>		20c. LOCATION — City or Town, State <i>Catonsville, Md</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sola March</i>				22. NAME AND ADDRESS OF FACILITY <i>March F. H. West</i> <i>4300 Walsh Ave Balt MD 21215</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Metastatic Prostatic Cancer</i>					
		b. <i>Anemia</i>					
		c. <i>Thrombocytopenia</i>					
		d. <i>infection</i>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>HOSPICE</i>					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Attending Physician</i>		29c. LICENSE NUMBER <i>D30115</i>		29d. DATE SIGNED (Month, Day, Year) <i>5/8/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>T. Ohiorokpehi, MD 2600 Liberty Hgts Ave Bt 1 MD 21215</i>							
31. DATE (Month, Day, Year) <i>MAY 1 2 1995</i>		32. REGISTRAR'S SIGNATURE <i>John Hudson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

4

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MCCRAW PEARLELL JOHNS</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>8</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>11:00 A M</b>	
4. SOCIAL SECURITY NUMBER <b>226-12-6656</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT 12, 1922</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>ST Agnes Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>NA</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>NA</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>526 Allendale St</b>			
10f. ZIP CODE <b>21229</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th grade</b> College (14 or 5+) <b>NA</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Brick Layer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Bethlehem Steel</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Enoch D. Johns</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Della McCraw</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Catherine Johns</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>526 Allendale St. Baltimore, MD 21229</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ROUNDON Park Cem 5/10/95</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Sola March</b>				22. NAME AND ADDRESS OF FACILITY <b>March F.H. West 4300 Wabash Ave. Baltimore 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>INTRACEREBRAL HEMORRHAGE</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>MYOCARDIAL INFARCTION</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>1 hour</b> <b>30 hours</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>RESIDENT</b>				29c. LICENSE NUMBER <b>2056</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 8, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RONALD MCLEARN 900 CATON AVE, BALTIMORE MD, 21229</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>J. H. [Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95-2728-510

Items 10a, 10e, 17 5-12-95 Film G723 W.H. Per F/H  
Item 18 5-19-95 G Film 723 W.H. Per F/H

95 14663

1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>JOHN JACKSON, Jr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 10 95</b>		3. TIME OF DEATH <b>5:54 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>247 46 1646</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>66</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3/14/29</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>ST. AGNES HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>S.C.</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Md</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2833 N. Denham Cir</b>				10f. ZIP CODE <b>21225</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Crane Operator</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Steel</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Jackson Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mattie Kelly</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Bartholomew Jackson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>902 St. Agnes Ln. Balto., Md. 21207</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Zion</b>		20c. LOCATION — City or Town, State <b>5/16 Balto., Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James A. Morton</i>				22. NAME AND ADDRESS OF FACILITY <b>James A. Morton &amp; Sons</b> <b>1701 Laurens St. Balto. Md. 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Coronary Thrombosis</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Atherosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James J. Chute MD</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 11, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>							

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14664

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Kathleen F. Kreppel				2. DATE OF DEATH MONTH DAY YEAR May 06 1995		3. TIME OF DEATH 2:00 A. M	
4. SOCIAL SECURITY NUMBER 213 32 9468		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 18, 1936	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 30 Brookfield Road		9b. CITY, TOWN OR LOCATION OF DEATH Pasadena	
9c. COUNTY OF DEATH Anne Arundel				10a. STATE Maryland		10b. COUNTY Worcester	
10c. CITY, TOWN OR LOCATION Berlin				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 11003 Gray's Corner Road Unit 124	
10f. ZIP CODE 21811				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cashier		16b. KIND OF BUSINESS/INDUSTRY Hospital	
17. FATHER'S NAME (First, Middle, Last) William Starr Gaitley				18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine Virginia Schrieber			
19a. INFORMANT'S NAME (Type/Print) William Kreppel				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11003 Gray's Corner Rd. Unit 124 Berlin, Md. 21811			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Cross Cemetery 5/9		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George J. Gonce</i>				22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Obstructive Jaundice</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Met. Pancreatic CA</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death c months 6 months Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. David Schwartz</i>				29c. LICENSE NUMBER H17744		29d. DATE SIGNED (Month, Day, Year) 5/8/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. David Schwartz 300 Hospital Drive Suite 215 Glen Burnie, Maryland 21061							
31. DATE FILED (Month, Day, Year) MAY 12 1995				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14665

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Dorothy L LEBEAU</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>10</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>4:19 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>038 056884</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 3, 1917</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Harbor Hospital Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>N.A.</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>N.A.</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>817 Pontiac Avenue</b>			
10f. ZIP CODE <b>21225</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 9th</b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Home Maker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Elmer Lockwood</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Maude Parker</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Janet Shane</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>817 Pontiac Avenue Baltimore, Maryland 21225</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Ann's Cemetery</b>		20c. LOCATION — City or Town, State <b>5/13 Cranston, Rhode Island</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</b>			
23. PART I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Refractory Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <b>11 days</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29b. LICENSE NUMBER <b>AS2441614</b>		29c. DATE SIGNED (Month, Day, Year) <b>MAY 10, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARY JOELINE J. MINOZZO, M.D.</b> <b>3001 S. Hanover St. Balto, Md. 21225</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Rosa Luster				2. DATE OF DEATH MONTH DAY YEAR May 6, 1995				3. TIME OF DEATH 05:00 A. M.	
4. SOCIAL SECURITY NUMBER 218-09-8098		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 83 YRS.	7. DATE OF BIRTH (Month, Day, Year) 10-17-11		8. BIRTHPLACE (State or Foreign Country) VA			
9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH n/a	
RESIDENCE OF DECEDENT									
10a. STATE MD		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 627 Mt. Holly St.				10f. ZIP CODE 21229		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unk. College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic N/A		16b. KIND OF BUSINESS/INDUSTRY Clothing Factory Home Maker					
17. FATHER'S NAME (First, Middle, Last) Sterling Marshall Merrick				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cherry Brown					
19a. INFORMANT'S NAME (Type/Print) Ardenia Merrick				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1622 Wadsworth Way Balto., MD 21239					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Pk. 5/10		20c. LOCATION — City or Town, State Randalstown, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James A. Morton</i>				22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons Funeral Hm 1701 Laurens St. Balto., MD 21217					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Sepsis</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Infected decubitus ulcer</i>								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Severe metabolic acidosis</i> <i>Severe dehydration</i>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Prudence K. Jackson, MD</i>				29c. LICENSE NUMBER D-37659		29d. DATE SIGNED (Month, Day, Year) May 6, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 400 CATON AVE, Baltimore MD 21229									
31. DATE FILED (Month, Day, Year) MAY 12 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Wendell Muldrow, Sr.				2. DATE OF DEATH MONTH DAY YEAR May 11, 1995		3. TIME OF DEATH 2:05 A M					
4. SOCIAL SECURITY NUMBER 251-46-8550		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH Month, Day, Year JAN. 2, 1933		8. BIRTHPLACE (State or Foreign Country) S. C AROLINA			
9a. FACILITY NAME (If not institution, give street and number) 2811 Kirk Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH N/A			
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND DAYWALT AVENUE 5901				10f. ZIP CODE 21206		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 TH		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BETHLEHEM LABORER		16b. KIND OF BUSINESS/INDUSTRY STEEL INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) AARON MULDROW				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARIE JOHNSON							
19a. INFORMANT'S NAME (Type/Print) FRIEDA MULDROW				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5901 DAYWALT AVENUE, BALTIMORE, MD 21206							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VA CEM. 5-15		20c. LOCATION — City or Town, State OWINGS MILLS, MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Karen M. Koger				22. NAME AND ADDRESS OF FACILITY March Funeral Home East 1101 E. North Avenue/Baltimore, MD 21202							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HEPATIC FAILURE DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. METASTATIC STOMACH CANCER TO THE LIVER DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								Approximate Interval Between Onset and Death ONE week 6 months			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Michael J. Kelly MD				29c. LICENSE NUMBER D43008		29d. DATE SIGNED (Month, Day, Year) 5/11/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL J. KELLY MD PhD JOHNS HOPKINS ONCOLOGY LEARN 600 NORTH WOLFE ST. BAL MD 21207											
31. DATE FILED (Month, Day, Year) MAY 12 1995				32. REGISTRAR'S SIGNATURE Audrey R. Raloff							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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95 14668

Items#10.e.17. G-film 723 per F.H 5/12/95 P.C

1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EDDIE JAMES MCFATTEN JR.</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>9</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>5:45 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>216-86-2317</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>30</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAY 25, 1964</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>BAYVIEW HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>n/a</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>n/a</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2119 ORLEANS STREET</b>				10f. ZIP CODE <b>21231</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11 TH</b> College (1-4 or 5+) <b>—</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CABINET MAKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOME IMPROVEMENT CARPENTER</b>			
17. FATHER'S NAME (First, Middle, Last) <b>EDDIE MC FATTEN SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BRENDA RAY</b>			
19a. INFORMANT'S NAME (Type/Print) <b>BRENDA MINTEN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2119 ORLEANS STREET, BALTIMORE, MD 21231</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>VOSHALL MEMORIAL GARDENS</b>		20c. LOCATION — City or Town, State <b>5-15 DUNDALK, MARYLAND</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Karen M. Hogan</b>				22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FH.-1101 E. NORTH AVENUE</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Central Nervous System Lymphoma</b>					Approximate Interval Between Onset and Death <b>1 week</b>
		b. <b>Retrolental Syndrome</b>					<b>3 years</b>
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. _____					
		d. _____					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. [Signature]</b>				29c. LICENSE NUMBER <b>NY173448</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 10 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>CV Plowe Div of Infectious Diseases Johns Hopkins Hospital Baltimore MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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95 14669

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>ELI W. MILLER</u>				2. DATE OF DEATH MONTH DAY YEAR <u>MAY 10 1995</u>		3. TIME OF DEATH <u>2:45 A M</u>	
4. SOCIAL SECURITY NUMBER <u>232 01 9508</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>77</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>June 4, 1917</u>	
8. BIRTHPLACE (State or Foreign Country) <u>West Virginia</u>				9a. FACILITY NAME (If not institution, give street and number) <u>Harbor Hospital Center</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>	
9c. COUNTY OF DEATH <u>N.A.</u>				10a. STATE <u>Maryland</u>			
10b. COUNTY <u>Baltimore</u>				10c. CITY, TOWN OR LOCATION <u>Baltimore</u>			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <u>2802 Georgia Avenue</u>			
10f. ZIP CODE <u>21227</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th</u> College (1-4 or 5+) <u></u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Skilled Worker</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Home Improvement</u>	
17. FATHER'S NAME (First, Middle, Last) <u>Estel T. Miller</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Emma M. Spangler</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Margaret Smith</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3015 Maryland Avenue Baltimore, Maryland 21227</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Crest Lawn Cemetery</u>		20c. LOCATION — City or Town, State <u>5/12 Baltimore, Maryland</u>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>George J. Gonce</u>				22. NAME AND ADDRESS OF FACILITY <u>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</u>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>ACUTE RENAL FAILURE</u> DUE TO (OR AS A CONSEQUENCE OF): <u>CHRONIC RENAL FAILURE</u> DUE TO (OR AS A CONSEQUENCE OF): <u>CARCINOMA COLON / MASS LESION IN @ LUNG</u> DUE TO (OR AS A CONSEQUENCE OF): <u>URETHRAL STRICTURE</u> Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>NOW INSULIN DEPENDENT DIABETES MELLITUS</u> <u>HYPERTENSION, CHRONIC OBSTRUCTIVE LUNG DISEASE</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Thomas J. Kottravick</u>				29c. LICENSE NUMBER <u>52441614-21</u>		29d. DATE SIGNED (Month, Day, Year) <u>MAY 10 1995</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>THOMAS J. KOTTRAVICK HARBOR HOSPITAL CENTER, 3001, S. HANOVIA STREET, BALTIMORE, MD. 21225</u>							
31. DATE FILED (Month, Day, Year) <u>MAY 12 1995</u>				32. REGISTRAR'S SIGNATURE <u>J. A. [Signature]</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GEORGE W. MORAN</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>9th</b> YEAR <b>95</b>		3. TIME OF DEATH <b>1-05P</b>	
4. SOCIAL SECURITY NUMBER <b>ZZO-28-9316</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>53</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jul 1, 1941</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Sinai Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>3508 Beech Avenue (Apt E)</b>			
10f. ZIP CODE <b>21211</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Telephone Solicitation</b>		16b. KIND OF BUSINESS/INDUSTRY <b>unknown</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Lyeth Moran</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Norma Smith</b>			
19a. INFORMANT'S NAME (Type/Print) <b>John Moran</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3508 Beech Ave, (Apt F), Baltimore, Md 21211</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Green Mount Cem. 5/11/95</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>A. Alan Seitz, Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Md 21211</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>INTRACEREBRAL BLEED.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>HTN.</b> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>W. Desai</b>		29c. LICENSE NUMBER <b>2707</b>		29d. DATE SIGNED (Month, Day, Year) <b>05/09/95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>UTWALA DESAI SINAI HOSPITAL</b>							
31. DATE FILED (Month, Day, Year) <b>05/10 MAY 1995</b>		32. REGISTRAR'S SIGNATURE <b>John H. ...</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14671

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Rose DeLuca MANGANO				2. DATE OF DEATH MONTH DAY YEAR May 7, 1995		3. TIME OF DEATH 8:05 p M	
4. SOCIAL SECURITY NUMBER 215-28-6181		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 12, 1915	
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Rossville		9c. COUNTY OF DEATH Baltimore County			
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Overlea/Fullerton	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 7913 Hilltop Avenue			
10f. ZIP CODE 21236				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 yrs.		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Self-Employed		16b. KIND OF BUSINESS/INDUSTRY Nu-Look Cleaners			
17. FATHER'S NAME (First, Middle, Last) Unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Unknown			
19a. INFORMANT'S NAME (Type/Print) Mrs. Angela R. M. Dunn				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7913 Hilltop Ave. Baltimore, Md. 21236			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory Inc. 5-9-95		20c. LOCATION — City or Town, State Baltimore, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Heather Lassahn</i>				22. NAME AND ADDRESS OF FACILITY Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Massive Right Hemispheric Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 3days							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>P. A. Baltatzis</i>				29c. LICENSE NUMBER D28949		29d. DATE SIGNED (Month, Day, Year) May 7, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Panayiotis Baltatzis, M.D., 9000 Franklin Square Drive, Baltimore, Maryland 21237							
31. DATE FILED (Month, Day, Year) MAY 12 1995		32. REGISTRAR'S SIGNATURE <i>John Anderson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RUTH M Nash</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>11</b> , YEAR <b>1995</b>		3. TIME OF DEATH <b>01:25 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>217-74-5913</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>35</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11/25/59</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>University Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>n/a</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>n/a</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4010 Bereva Road</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Data Entry</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Insurance</b>			
17. FATHER'S NAME (First, Middle, Last) <b>James Oliver Nash, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marie Johnson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Marie J. Powell</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4010 Bereva Road Baltimore, Maryland 21215</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>King Memorial Park 5/16</b>		20c. LOCATION — City or Town, State <b>4/16 Randallstown, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i>				22. NAME AND ADDRESS OF FACILITY <b>LEROY O. DYETT &amp; SON FUNERAL HOME 4600 Liberty Heights Avenue 21207</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b> Approximate Interval Between Onset and Death <b>2 days</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>Amyotrophic Lateral Sclerosis</b> 3+ years c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Obesity</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Spencer S. Markowitz, MD</i>		29c. LICENSE NUMBER <b>P08677</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/11/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SPENCER S. MARKOWITZ, MD UNIVERSITY OF MARYLAND MEDICAL CENTER</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>		32. REGISTRAR'S SIGNATURE <i>J. A. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14673

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) STANLEY WALTER PIRZCHALSKI				2. DATE OF DEATH MAY 1995 6th 06:45 PM		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 217 01 0497		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 20, 1912	
9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE		9c. COUNTY OF DEATH A.A. COUNTY	
10a. STATE Maryland				10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Pasadena	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 1817 Division Road				10f. ZIP CODE 21122		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Glazier		16b. KIND OF BUSINESS/INDUSTRY Glass Industry			
17. FATHER'S NAME (First, Middle, Last) John Pirezchalski				18. MOTHER'S NAME (First, Middle, Maiden Surname) Julia Rykowski			
19a. INFORMANT'S NAME (Type/Print) Jennie Pirezchalski				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1817 Division Road Pasadena, Maryland 21122			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Memorial Park 5/10		20c. LOCATION — City or Town, State Glen Burnie, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donna M. Zmizowski				22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive Failure Arteriosclerotic Heart Disease Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Approximate interval between Onset and Death 3 days 10 min.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Respiratory Failure DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Hilary T. O'Herlihy, M.D.				29c. LICENSE NUMBER D15860		29d. DATE SIGNED (Month, Day, Year) 5-10-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HILARY T. O'HERLIHY, M.D./325 HOSPITAL DRIVE, #208/GLEN BURNIE, MARYLAND 21061							
31. DATE FILED (Month, Day, Year) MAY 12 1995				32. REGISTRAR'S SIGNATURE Jill A. Carroll			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14674

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Richard Portner Jr.				2. DATE OF DEATH MONTH DAY YEAR May 10 95		3. TIME OF DEATH 12:27 PM M	
4. SOCIAL SECURITY NUMBER 215-28-0676		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb 18, 1933	
9a. FACILITY NAME (If not institution, give street and number) Fort Howard VAMC				9b. CITY, TOWN OR LOCATION OF DEATH Ft. Howard		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3970 Falls Road				10f. ZIP CODE 21211		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 4/6/53- 3/15/55		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 11 College (1-4 or 5+) 11				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) House Painter		16b. KIND OF BUSINESS/INDUSTRY Self Employed	
17. FATHER'S NAME (First, Middle, Last) Richard E. Portner				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lola (unknown)			
19a. INFORMANT'S NAME (Type/Print) Joann Nace				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3970 Falls Road Baltimore, Maryland 21211			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Cemetery 5/16/95		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>A. Alan Seitz, Jr.</i>				22. NAME AND ADDRESS OF FACILITY A. Alan Seitz, Jr. Funeral Home 3818 Roland Ave., Baltimore, Maryland 21211			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Cancer Of Prostate with Metastasis DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sacral and Heel Decubitus ulcers							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>C. Custodio, M.D.</i>				29c. LICENSE NUMBER D-15628		29d. DATE SIGNED (Month, Day, Year) 5/10/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Carolina Custodio, MD 9600 North Point Road Fort Howard, MD 21052							
31. DATE FILED (Month, Day, Year) MAY 12 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 14675

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Charlotte Lawrence Renner</i>				2. DATE OF DEATH MONTH <i>May</i> DAY <i>6</i> YEAR <i>1995</i>				3. TIME OF DEATH <i>4:00 A.M.</i>			
4. SOCIAL SECURITY NUMBER <i>212-32-5375</i>				5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>60</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Aug. 7, 1934</i>		8. BIRTHPLACE (State or Foreign Country) <i>Baltimore City, Md.</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Fallston General Hospital</i>						9b. CITY, TOWN OR LOCATION OF DEATH <i>Fallston</i>			9c. COUNTY OF DEATH <i>Harford</i>		
RESIDENCE OF DECEDENT											
10a. STATE <i>Maryland</i>			10b. COUNTY <i>Harford</i>			10c. CITY, TOWN OR LOCATION <i>Forest Hill</i>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <i>1706 M Landmark Drive</i>						10f. ZIP CODE <i>21050</i>			10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i>				15b. KIND OF BUSINESS/INDUSTRY <i>Home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Edward C. Lawrence</i>						16. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Anna Wheeler</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Donald H. Renner, Sr.</i>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1706 M Landmark Dr. Forest Hill, Md. 21050</i>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Gardens of Faith Mausoleum May 9, 1995</i>				20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>E. F. Lassahn</i>						22. NAME AND ADDRESS OF FACILITY <i>E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, Md. 21087</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>End stage congestive heart failure secondary to</i>											
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
a. DUE TO (OR AS A CONSEQUENCE OF): ① <i>Ischemic and diabetic cardiomyopathy</i> b. DUE TO (OR AS A CONSEQUENCE OF): ② <i>Coronary artery disease and mitral valve replacement</i> c. DUE TO (OR AS A CONSEQUENCE OF): ③ <i>Extensive peripheral vascular disease</i>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Multifactorial dementia, Diabetic nephropathy Multifactorial anemia, Fecal impaction</i>											
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <i>N/A</i>		28b. TIME OF INJURY <i>N/A</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <i>N/A</i>	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Muthulakshmi MD</i>				29c. LICENSE NUMBER <i>D44248</i>		29d. DATE SIGNED (Month, Day, Year) <i>May 6<sup>th</sup>, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>MUTHULAKSHMI RAMESH Potomac Physicians MD 21015</i>											
31. DATE FILED (Month, Day, Year) <i>MAY 12 1995</i>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
**CERTIFICATE OF DEATH** REG. NO.

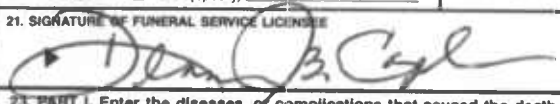
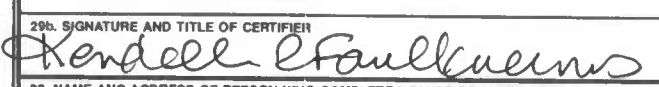

REG. NO.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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1. DECEDENT'S NAME (First, Middle, Last) <b>AUDREY CLEMENTINE SPEIGHT</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>8</b> YEAR <b>95</b>				3. TIME OF DEATH <b>1:45/A</b>											
4. SOCIAL SECURITY NUMBER <b>212-32-6539</b>				5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>59</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		7. DATE OF BIRTH (Month, Day, Year) <b>Feb 07, 1936</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Cardinal Shehan Ctr (Stella Maris)</b>								9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>				9c. COUNTY OF DEATH <b>Baltimore</b>							
RESIDENCE OF DECEDENT																			
10a. STATE <b>Md.</b>				10b. COUNTY				10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>410 N. Patterson Park Avenue</b>								10f. ZIP CODE <b>21205</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College</b>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Domestic</b>				15b. KIND OF BUSINESS/INDUSTRY <b>Housewife</b>											
17. FATHER'S NAME (First, Middle, Last) <b>Bernard Pritchett</b>								18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Evelina L. Poag</b>											
19a. INFORMANT'S NAME (Type/Print) <b>Cacheeta M. Speight</b>								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2620 W. Coldspring Lane Baltimore, Md. 21215</b>											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Crownsville Veterans 5/12/95</b>				20c. LOCATION — City or Town, State <b>Crownsville, Maryland</b>											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 								22. NAME AND ADDRESS OF FACILITY <b>Caple Funeral Service 5502 Winner Ave. Baltimore, Md. 21215</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RENAL FAILURE</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>AMYLOIDOSIS</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.																Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>																24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>															
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED									
29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. SIGNATURE AND TITLE OF CERTIFIER 								29c. LICENSE NUMBER <b>D25643</b>				29d. DATE SIGNED (Month, Day, Year) <b>5/8/95</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. KENDALL FAULKNER 2300 DULANEY VALLEY ROAD TOWSON, MD 21204</b>																			
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>				32. REGISTRAR'S SIGNATURE 															



95 14677

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Rose Sneed</b>				2. DATE OF DEATH MONTH <b>(MAY)</b> DAY <b>5</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>2:15 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>215-12-9738</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>April 10, 1932</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Sinai Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH				10a. STATE <b>MD</b>				10b. COUNTY	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>4161 Labyrinth Road</b>				10f. ZIP CODE <b>21215</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th grade</b> College (1-4 or 5+) <b>NA</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Domestic Work</b>				16b. KIND OF BUSINESS/INDUSTRY <b>HOME</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John Montgomery</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Blanche Woodbeck</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Janet Brown</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4161 Labyrinth Rd Baltimore, MD 21215</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>King Mem Park 5/5/95</b>				20c. LOCATION — City or Town, State <b>Randallstown, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Solo March</b>				22. NAME AND ADDRESS OF FACILITY <b>March F.H. West 4300 Webster Ave</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ARDS (Adult respiratory distress syndrome)</b> DUE TO (OR AS A CONSEQUENCE OF): <b>SEPSIS</b> DUE TO (OR AS A CONSEQUENCE OF): <b>NECROTIZING FASCIITIS</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Undetermined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Thomas Genuit MD</b>				29c. LICENSE NUMBER <b>Hopkins M2988/SINAI 1995</b>				29d. DATE SIGNED (Month, Day, Year) <b>5/9/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Thomas Genuit MD, Dept. Surgery, Sinai Hosp. Baltimore Md</b>									
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>Jabir Shukor-Rahel</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14678

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Mary R. Simpson</i>				2. DATE OF DEATH MONTH <i>May</i> DAY <i>8</i> YEAR <i>95</i>		3. TIME OF DEATH <i>1:50 PM</i>	
4. SOCIAL SECURITY NUMBER <i>217-26-6830</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <i>65</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>1-14-1930</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Northwest Hospital Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Randallstown</i>		9c. COUNTY OF DEATH <i>Balto</i>	
RESIDENCE OF DECEDENT				10c. CITY, TOWN OR LOCATION <i>Baltimore</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10a. STATE <i>MD</i>		10b. COUNTY <i>NA</i>		10e. STREET AND NUMBER <i>3117 Jeffrey Road</i>		10f. ZIP CODE <i>21244</i>	
10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11th grade</i> College (14 or 5+) <i>2 yrs</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Nurse</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Hospital</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Charlie Staton, Sr</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Cora Bridge</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Sharon Staton Resper</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>522 Edgewood St Balto, Md 21229</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Woodlawn Cemetery 5/13/95</i>		20c. LOCATION — City or Town, State <i>Baltimore, Md</i>		22. NAME AND ADDRESS OF FACILITY <i>March F.H. West 4300 Wabash Ave Balto, Md 21215</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jala March</i>				22. NAME AND ADDRESS OF FACILITY <i>March F.H. West 4300 Wabash Ave Balto, Md 21215</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Respiratory failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Obstructive pulmonary - smoker</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Coronary atherosclerosis</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>pulmonary hypertension</i> Approximate Interval Between Onset and Death <i>minutes</i> <i>minutes</i> <i>several years</i> <i>several years</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE NOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Alice S. Horst</i>		29c. LICENSE NUMBER <i>H 43974</i>		29d. DATE SIGNED (Month, Day, Year) <i>May 8, 95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Hsieh, Alice Northwest Hospital Randallstown, Md</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 12 1995</i>		32. REGISTRAR'S SIGNATURE <i>Jala March</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14679

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>NORA SHORTER</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>7</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>6:55P</b> M	
4. SOCIAL SECURITY NUMBER <b>219-01-1440</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept 16, 1922</b>	
8. BIRTHPLACE (State or Foreign Country) <b>md</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Northwest Hospital</b>		9b. CITY/TOWN OR LOCATION OF DEATH <b>Balto</b>	
9c. COUNTY OF DEATH <b>Balto</b>				10a. STATE <b>md</b>			
10b. COUNTY <b>N/A</b>				10c. CITY/TOWN OR LOCATION <b>Balto</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1230 W. Lafayette Ave</b>			
10f. ZIP CODE <b>21217</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (14 or 5+) <b>N/A</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life—Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOME</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William Chambers</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dorothy Jones</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Warner Shorter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1230 W. Lafayette Ave Balto, md 21217</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus Mem. Pk 5/11/95</b>		20c. LOCATION — City or Town, State <b>Arbutus, md</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Walter Edmundo</b>				22. NAME AND ADDRESS OF FACILITY <b>March L. H. - West 4300 Wabash Ave</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal Failure</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Michael J. [Signature]</b>				29c. LICENSE NUMBER <b>D40521</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/9/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. OCHANEY NORTHWEST HOSPITAL CENTER 5401 OLD COURT ROAD RANDALLSTOWN MD 21133</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>John [Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14680

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Martha Schmidt</u>				2. DATE OF DEATH MONTH <u>MAY</u> DAY <u>6</u> YEAR <u>95</u>		3. TIME OF DEATH <u>6:05 AM</u>		
4. SOCIAL SECURITY NUMBER <u>214-54-6802</u>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <u>96</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Aug. 19, 1898</u>		8. BIRTHPLACE (State or Foreign Country) <u>Germany</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>John Hopkins Geriatric Center</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>		9c. COUNTY OF DEATH <u>n/a</u>		
10a. STATE <u>Md.</u>		10b. COUNTY <u>Baltimore</u>		10c. CITY, TOWN OR LOCATION <u>Baltimore</u>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER <u>431 Imla Street</u>				10f. ZIP CODE <u>21224</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6th</u> College (1-4 or 5+) <u>Housewife</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Housewife</u>		16b. KIND OF BUSINESS/INDUSTRY <u>own home</u>				
17. FATHER'S NAME (First, Middle, Last) <u>Otto Kroll</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Anna ==</u>				
19a. INFORMANT'S NAME (Type/Print) <u>Bill Schmidt</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>431 Imla Street Baltimore Md. 21224</u>				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Oak Lawn Cemetery</u> <u>5/8/95</u>		20c. LOCATION — City or Town, State <u>Baltimore Md.</u>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>R. Terry Connelly</u>				22. NAME AND ADDRESS OF FACILITY <u>Connelly Funeral Home of Essex</u> <u>300 Mace Ave. Baltimore Md. 21221</u>				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>urosepsis</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <u>urosepsis</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>DEMENTIA</u> <u>BULLOUS PEMPHIGOID</u> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>						Approximate Interval Between Onset and Death <u>6d</u>		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u>				29c. LICENSE NUMBER <u>D37089</u>		29d. DATE SIGNED (Month, Day, Year) <u>5.8.95</u>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>BRUCE LEFF MD. 5505 HOPKINS BAYVIEW CIRCLE BALT MD 21224</u>								
31. DATE FILED (Month, Day, Year) <u>MAY 12 1995</u>		32. REGISTRAR'S SIGNATURE <u>[Signature]</u>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14681

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HELEN RUTH SCHWEIGER</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>11</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>12:00 pm</b> M	
4. SOCIAL SECURITY NUMBER <b>216-12-7362</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>88</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 19, 1907 Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Saint Joseph Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson, Maryland</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Parkville</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2909 Andonna Rd. Apt. C</b>				10f. ZIP CODE <b>21234</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Benjamin F. Christopher</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary E. Cormann</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. June Earles</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3319 Acton Rd. Balto., Md. 21234</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gardens Of Faith Cem. 5/15 Balto., Md.</b>		20c. LOCATION — City or Town, State		Approximate interval Between Onset and Death <b>+1 HOUR</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Spady D. Smith</i>				22. NAME AND ADDRESS OF FACILITY <b>Hantley Miller Funeral Home 7527 Harford Rd. Balto., Md. 21234</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		<b>a. RESPIRATORY FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. ASPIRATION PNEUMONITIS</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. HEMATURESIS</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. BLEEDING GASTROINTESTINAL TRACT</b>					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		Approximate interval Between Onset and Death <b>2 HOUR</b> <b>1 MONTH</b> <b>6 MONTHS</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>E. A. Bohorquez MD</i>				29c. LICENSE NUMBER <b>D 17667</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/11/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type/Print) <b>FERNANDO BOHORQUEZ, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DATE: May 11, 1987  
TO: SCHWABER  
FROM: [illegible]

RE: Saint Joseph Medical Center  
Toward Maryland  
Baltimore

RESPIRATORY FAILURE  
ASPIRATION PNEUMONIA  
HEMATURIA  
BLEEDING GASTROINTESTINAL TRACT

RE: [illegible]  
D: 1987  
REYNOLD BOHANNON, M.D., 2600 YORK ROAD TOWSON, MARYLAND 21204



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Fred Andrew Tangeman</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 7 1995</b>		3. TIME OF DEATH <b>10:00 AM</b>	
4. SOCIAL SECURITY NUMBER <b>390-07-5451</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>October 12, 1907</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>4949 Mountain Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Pasadena</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Pasadena</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4949 Mountain Road</b>				10f. ZIP CODE <b>21122</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO If YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Salesman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Food Industry</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Eldo Tangeman</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lena Kaeser</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Judy Wheeler</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4949 Mountain Road Pasadena, Maryland 21122</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Forest Hill Cemetery</b>		20c. LOCATION — City or Town, State <b>Madison, Wisconsin</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael P. Marzullo</i>				22. NAME AND ADDRESS OF FACILITY <b>Marzullo Funeral Service 3981 Carrollton Road Upperco, Maryland 21155</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Chronic Obstructive Pulmonary Disease</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. <b>10 years</b>						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Senile Dementia</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mayer Gorbaty M.D.</i>				29c. LICENSE NUMBER <b>027938</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/9/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Mayer Gorbaty M.D. 795 Appleton Rd. Glen Burne MD 21041</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julia A. Wilson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14683

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Preston Williams				2. DATE OF DEATH MONTH DAY YEAR May 5, 1995		3. TIME OF DEATH 11:00 A M	
4. SOCIAL SECURITY NUMBER 717-12-3916		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 5, 1917	
9a. FACILITY NAME (If not institution, give street and number) 4917 Goodnow Road				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Balto	
RESIDENCE OF DECEASED							
10a. STATE Md		10b. COUNTY Balto		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4917 Goodnow Road				10f. ZIP CODE 21208		10g. CITIZEN OF WHAT COUNTRY? U S A	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 7th College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Fork Lift Operator		16b. KIND OF BUSINESS/INDUSTRY McCormick Co.			
17. FATHER'S NAME (First, Middle, Last) Sam Williams				18. MOTHER'S NAME (First, Middle, Maiden Surname) Carrie Ballard			
19a. INFORMANT'S NAME (Type/Print) Josephine DeLane				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Quimper Court Apt 2 B Baltimore, Md 21208			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet		DATE 51295		20c. LOCATION — City or Town, State Owings Mills, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sala March</i>				22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue Balto, Md 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M		26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		26d. DESCRIBE HOW INJURY OCCURRED		26e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chute</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) MAY 12/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DENNIS CHUTE M.D. 111 PENN STREET, BALTIMORE, MARYLAND 21201							
31. DATE FILED (Month, Day, Year) MAY 12 1995				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14684

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>James Walker</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>10th</b> YEAR <b>95</b>		3. TIME OF DEATH <b>6:00a M</b>	
4. SOCIAL SECURITY NUMBER <b>212-40-0917</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>52</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>August 26, 1942</b>	
8. FACILITY NAME (If not institution, give street and number) <b>Liberty Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Balto</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>md</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Balto</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1301 Myrtle Avenue - 1st fl</b>			
10f. ZIP CODE <b>21217</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+) <b>N/A</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Construction worker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Construction</b>	
17. FATHER'S NAME (First, Middle, Last) <b>James Walker Sr.</b>				18. MOTHER'S NAME (First, Middle, Surname) <b>Fannie Perry</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Jerome Walker</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13 n. Hilton St. Balto, md 21229</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, repository or other place) <b>Western Star Cemetery, 5/13/95</b>		20c. LOCATION — City or Town, State <b>Catonsville, md</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Sale March</b>	
22. NAME AND ADDRESS OF FACILITY <b>March F.H. - West Ave 4300 Wabash Ave</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>Endstage Pancreatic Cancer</b> DUE TO (OR AS A CONSEQUENCE OF):  b. <b>Failure to Thrive</b> DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>May 10, 1995</b>	
28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Kerren Elder MD Medical House officer</b>		29c. LICENSE NUMBER <b>038993</b>	
29d. DATE SIGNED (Month, Day, Year) <b>5/10/95</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Kerren Elder MD 2600 Liberty Hgts Baltimore MD 21215</b>			
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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ITEMS: 23 PART I, 27, 28a, b, c, d, e, f, PER MEO G-723 5/12/95 reb

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LOUIS HIRSH WEISBACK</b>				2. DATE OF DEATH <b>APRIL 20 1995</b>		3. TIME OF DEATH <b>1:50P M</b>	
4. SOCIAL SECURITY NUMBER <b>577-32-9501</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>66 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 26, 1928</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Washington, DC</b>				9. COUNTY OF DEATH <b>PRINCE GEORGES</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>9508 BUCKLIDGE COURT</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ADELPHI</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGES</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince Georges</b>		10c. CITY, TOWN OR LOCATION <b>Adelphi</b>		10d. INSIDE CITY LIMITS? <b>YES 2 NO</b>	
10e. STREET AND NUMBER <b>9508 Buck Lodge Court</b>				10f. ZIP CODE <b>20783</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12 Yrs</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Contractor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home Improvement</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Daniel Weisbach</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Freda Greene</b>			
19a. INFORMANT'S NAME (Type/Print) <b>David George Weisbach</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7113 Clarendon Rd, Apt. 2, Bethesda, MD 20814</b>			
20a. METHOD OF DISPOSITION <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>King David Memorial Garden 4/23/95</b>		20c. LOCATION — City or Town, State <b>Falls Church, VA</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Donald C. Stottmeyer</b>				22. NAME AND ADDRESS OF FACILITY <b>STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL ST, NW, WASHINGTON, DC 20012</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>STAB WOUNDS</b>							
Due to (DR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
Due to (DR AS A CONSEQUENCE OF):							
Due to (DR AS A CONSEQUENCE OF):							
Due to (DR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>XX YES 2 NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>					
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year) <b>4/20/95</b>		28b. TIME OF INJURY <b>UNKNOWN</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>	
28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT STABBED HIMSELF</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>HOME</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>9508 Bucklodge Ct. ADELPHI, MD.</b>			
29a. CERTIFIER (Check only one) <b>XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 21/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>David R Fowler 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

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95 14686

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOHN THOMAS ZOOK</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 09 1995</b>		3. TIME OF DEATH <b>4:15 p. M</b>	
4. SOCIAL SECURITY NUMBER <b>176-14-9354</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>DECEMBER 26, 1920</b>	
8. BIRTHPLACE (State or Foreign Country) <b>OHIO</b>		9a. FACILITY NAME (If not institution, give street and number) <b>Harbor Hospital Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>N.A.</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>N.A.</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>3621 - 4th Street</b>			
10f. ZIP CODE <b>21225</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>World War II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Plumber</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Plumbing</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John L. Zook</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Louisa W. Waddington</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mae A. Zook</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3621 - 4th Street Baltimore, Maryland 21225</b>					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>		20c. DATE <b>5/11</b>		20d. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard E. Davis</i>				22. NAME AND ADDRESS OF FACILITY <b>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Cardiac Arrest</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Ventricular Fibrillation</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Cardiomyopathy</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Arteriosclerosis</b> Approximate Interval Between Onset and Death <b>10 min.</b> <b>10 min.</b> <b>2 years</b> <b>10 years</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edward A. Seidel M.D.</i>				29c. LICENSE NUMBER <b>M30177</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 9, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Edward A. Seidel, M.D. Harbor Hospital Center Emergency, 3001 S. Hanover Street Balto., MD 21225</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>		32. REGISTRAR'S SIGNATURE <i>John Andrew Parrell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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95 14687

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>HARRY W. ADEY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 9, 1995</b>		3. TIME OF DEATH <b>12:30 P. M.</b>	
4. SOCIAL SECURITY NUMBER <b>213 07 1084</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12 17 15</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Meridian-Franklin Woods</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rossville</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Md.</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>607 South Newkirk Street</b>			
10f. ZIP CODE <b>21224</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Unknown</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Supervisor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Bethlehem Steel</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George Adey</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lottie Pierman</b>			
19a. INFORMANT'S NAME (Type/Print) <b>David A. Adey</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4 Gavin Circle Andover, Mass. 01810</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery 5-13-95</b>		20c. LOCATION — City or Town, State <b>Eastwood, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Charles S. Zeiler</b>				22. NAME AND ADDRESS OF FACILITY <b>Charles S. Zeiler &amp; Son Inc. 6224 Eastern Ave. Balto., Md.</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>COPD - Resp Failure</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <b>10y.</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Ca of Heart</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Clayton Moravec</b>				29c. LICENSE NUMBER <b>M05925</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/9/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Clayton Moravec M.D. 9000 Franklin Square Drive. 21237</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRATION NUMBER <b>John D. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14688

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Chalmer Arnold</i>				2. DATE OF DEATH MONTH <i>May</i> DAY <i>11</i> YEAR <i>1995</i>				3. TIME OF DEATH <i>11:10 A.</i>					
4. SOCIAL SECURITY NUMBER <i>247-34-5219</i>				5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>69</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Aug 6, 1925</i>		8. BIRTHPLACE (State or Foreign Country) <i>S. C.</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>5819 Highgate Drive</i>						9b. CITY, TOWN OR LOCATION OF DEATH <i>Balto</i>				9c. COUNTY OF DEATH <i>NO</i>			
RESIDENCE OF DECEDENT													
10a. STATE <i>MD</i>				10b. COUNTY <i>NA</i>				10c. CITY, TOWN OR LOCATION <i>Balto</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>5819 Highgate Drive</i>						10f. ZIP CODE <i>21215</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th grade</i> College (1-4 or 5+) <i>NA</i>						15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Porter</i>				15b. KIND OF BUSINESS/INDUSTRY <i>Maryland Racing Association</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Moses Arnold</i>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Sullivan</i>							
19a. INFORMANT'S NAME (Type/Print) <i>Ella Arnold</i>						19b. MAILING ADDRESS (Street and Number or Rural/Route Number, City or Town, State, Zip Code) <i>5819 Highgate Drive Balto MD 21215</i>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Garrison Forest Vet 5/15/95</i>				20c. LOCATION — City or Town, State <i>Owings Mills, Md</i>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John Winfield Jordan</i>						22. NAME AND ADDRESS OF FACILITY <i>Mark F. H. West 4300 Walbrook Ave Balto, Md</i>							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Carcinoma of the prostate, metastatic</i>										Approximate Interval Between Onset and Death <i>18 months</i>			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ronald S. Pototsky</i>						29c. LICENSE NUMBER <i>D13004</i>				29d. DATE SIGNED (Month, Day, Year) <i>5/11/95</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>RONALD S. POTOTSKY MD 821 N. Eutam St BALTIMORE MD 21201</i>													
31. DATE FILED (Month, Day, Year) <i>MAY 15 1995</i>						32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14689

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HENRIETTA ARMSTRONG</b>				2. DATE OF DEATH May 11 1995		3. TIME OF DEATH 3:24 P M	
4. SOCIAL SECURITY NUMBER 215-24-7436		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov 22, 1920	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Liberty Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH n/a				10a. STATE Maryland		10b. COUNTY n/a	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 3933 Cedardale Road	
10f. ZIP CODE 21215				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic		16b. KIND OF BUSINESS/INDUSTRY Private Family	
17. FATHER'S NAME (First, Middle, Last) William Parker				18. MOTHER'S NAME (First, Middle, Maiden Surname) Henrietta Jordan			
19a. INFORMANT'S NAME (Type/Print) Mary F. Foster				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3933 Cedardale Road Baltimore, MD 21215			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial Park May 11		20c. LOCATION — City or Town, State Baltimore County, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mary F. Rollens</i>				22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>CORONARY ARTERY DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Anthony A. Dasilva MD</i>				29c. LICENSE NUMBER D32750		29d. DATE SIGNED (Month, Day, Year) May 11 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANTHONY A. DASILVA MD. LIBERTY MED CENTER, 2600 LIBERTY HEIGHTS 21215							
31. DATE FILED (Month, Day, Year) MAY 15 1995				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14690

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>Estelle Bost</b>				2. DATE OF DEATH MONTH <b>04</b> DAY <b>26</b> YEAR <b>95</b>		3. TIME OF DEATH <b>2:40 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>021-263972</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-11-07</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		8c. COUNTY OF DEATH <b>Baltimore</b>	
9. RESIDENCE OF DECEASED							
10a. STATE <b>MD</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4601 Paul May Rd</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>black</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>in state</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald Wade, Dir.</b>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board</b> <b>655 West Baltimore St., Balto., MD 21201</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>PNEUMONIA</b>					
		DUE TO (OR AS A CONSEQUENCE OF):					
		b. <b>ANOXIC ENCEPHALOPATHY</b>					
		DUE TO (OR AS A CONSEQUENCE OF):					
		c. <b>HYPERTENSION</b>					
		DUE TO (OR AS A CONSEQUENCE OF):					
		d.					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 7 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Nomicide 4 <input type="checkbox"/> Other		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>M. Greenfield</b>					
		29c. LICENSE NUMBER <b>AS2402321 9824</b>		29d. DATE SIGNED (Month, Day, Year) <b>04-26-95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Melinda A Greenfield, D.O. SINAI HOSPITAL</b>							
31. DATE FILED (Month, Day, Year) <b>04-26-95</b>		32. REGISTRAR'S SIGNATURE <b>John Andrew Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14691

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Billie Ann Buschman				2. DATE OF DEATH MONTH DAY YEAR May 2 1995		3. TIME OF DEATH 7:05 A M	
4. SOCIAL SECURITY NUMBER 217-72-3111		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 38 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 3, 1958	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) 11813 Quince Mill Drive		9b. CITY, TOWN OR LOCATION OF DEATH Rockville	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Rockville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 11813 Quince Mill Drive	
10f. ZIP CODE 20873				10g. CITIZEN OF WHAT COUNTRY?		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher's Assistant		16b. KIND OF BUSINESS/INDUSTRY Education	
17. FATHER'S NAME (First, Middle, Last) Albert J. Buschman JR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Carver			
19a. INFORMANT'S NAME (Type/Print) Doug Bushman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11813 Quince Mill Drive, Rockville, MD 20873			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir. <i>Joseph B. Van...</i>				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore St., Balto., MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Gastric Cancer</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John...</i>				29c. LICENSE NUMBER D32407		29d. DATE SIGNED (Month/Day/Year) 5/10/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOSEPH HASBERG 9707 MEDICAL CENTER DR ROCKVILLE MD 20850							
31. DATE FILED (Month, Day, Year) MAY 15 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14692

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Gracie Byerley</i>				2. DATE OF DEATH MONTH <i>May</i> DAY <i>11</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>3:00 AM</i>	
4. SOCIAL SECURITY NUMBER <i>415-44-1368</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>76</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>March 9, 1919</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Tenn.</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Meridian Nursing Cent. Long Green Baltimore,</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>N/A</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>N/A</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore City</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>6307 Eastern Pkwy.</i>		10f. ZIP CODE <i>21214</i>	
10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>College (1-4 or 5+)</i>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>John Frank Blair</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Allie Beeler</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Phyllis A. Heffler</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6307 Eastern Pkwy Baltimore, Md. 21214</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of place, date, and time) <i>Union Cemetery 5-14-95</i>		20c. LOCATION — City or Town, State <i>Knoxville, Tenn.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald C. Schick</i>				22. NAME AND ADDRESS OF FACILITY <i>Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <i>Intestinal Ischemia</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <i>Myocardial Infarction</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <i>Cardiomyopathy</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
d. <i>Squamous Cell Carcinoma of Lung</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic obstructive Pulmonary Disease</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check one box) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Fredrick S. Sirkis M.D.</i>				29c. LICENSE NUMBER <i>D22645</i>		29d. DATE SIGNED (Month, Day, Year) <i>5/11/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>FREDRICK S. SIRKIS, M.D., 7151 HOLABIRD AVE. BALTO, MD. 21222</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 15 1995</i>				32. REGISTRAR'S SIGNATURE <i>James A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


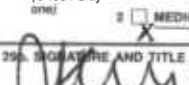
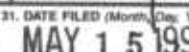
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last) <b>ANDERSON</b>		2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>13</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>2:02A</b>	
4. SOCIAL SECURITY NUMBER <b>216-34-4711</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>57</b> YRS.	
7. DATE OF BIRTH Month, Day, Year <b>MAR. 7, 1938</b>		8. BIRTHPLACE (State or Foreign Country) <b>N. CAROLINA</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>4710 PILGRIM RD.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City.</b>		9c. COUNTY OF DEATH <b>n/a</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>n/a</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>4710 PILGRIM ROAD</b>		10f. ZIP CODE <b>21214</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10 TH</b> College (1-4 or 5+) <b>-</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>L A B O R E R</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Railroad, Chemical Co.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>HENRY A. BEST</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EUNICE PHAIR</b>			
19a. INFORMANT'S NAME (Type/Print) <b>EUNICE BEST</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4710 PILGRIM ROAD, BALTIMORE, MARYLAND 21224</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>WM. ZION CEMETERY</b> DATE <b>5-16</b>		20c. LOCATION — City or Town, State <b>LANSDOWNE, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FH.-1101 E. NORTH AVENUE</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>O.C.M.E.</b>	
29d. DATE SIGNED (Month, Day, Year) <b>MAY 13, 1995</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GOLUB JR AND</b>		31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>	
32. REGISTRAR'S SIGNATURE 		33. REGISTRAR'S NAME <b>John A. Harkins</b>		34. REGISTRAR'S ADDRESS <b>311 Penn Street, Baltimore, Maryland 21201.</b>	

DMMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95-2706-510

b1h ITEMS: 10e, PER F.H. FILM G-723 5/15/95 t.t

95 14694

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) <b>James Bellamy Jr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 10 1995</b>		3. TIME OF DEATH <b>0247</b> M	
4. SOCIAL SECURITY NUMBER <b>241--72-- 2655</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>51</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>APRIL 23, 1944</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Maryland General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>n/a</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>n/a</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>325 MC MEHEN ST.</b>			
10f. ZIP CODE <b>21217</b>				10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>AIRFORCE</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12 TH</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CLERICAL</b>		16b. KIND OF BUSINESS/INDUSTRY <b>BALTIMORE COUNTY DEPT. of SANITATION</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JAMES BELLAMY SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>PAULINE MC KEEVES</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CLARISE BELLAMY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>325 MC MEHEN ST. APT. 201, Baltimore, MD 21217</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARRISON FOREST VA C EM.</b>		DATE <b>5-16</b>		20c. LOCATION — City or Town, State <b>OWINGS MILLS, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FH.1-101 E. NORTH AVENUE</b>			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death	
24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				24c. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 10 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GOLIE JR MD 111 Penn Street, Baltimore, Maryland 21201</b>					
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>		32. REGISTRAR'S SIGNATURE 			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BERNADETTE A. BARCZAK				2. DATE OF DEATH MONTH DAY YEAR May 10, 1995		3. TIME OF DEATH 6:30 p.m.	
4. SOCIAL SECURITY NUMBER 215-22-4110		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 4, 1928	
9a. FACILITY NAME (If not institution, give street and number) Mercy Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH n/a	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 816 Wellington Rd.				10f. ZIP CODE 21212		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Simon P. Jarosinski				18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Kwiatkowski			
19a. INFORMANT'S NAME (Type/Print) Dr. Edward M. Barczak				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10a-f			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem.Gdns. 5/13/95		OATE		20c. LOCATION — City or Town, State Timonium, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of Lung DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peripheral vascular disease							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO n/a
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) n/a		28b. TIME OF INJURY n/a		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) n/a		28d. DESCRIBE HOW INJURY OCCURRED n/a			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D30142		29d. DATE SIGNED (Month, Day, Year) 5/10/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Edward M. Barczak 301 S. Park Ave + 209 Baltimore MD 21202							
31. DATE FILED (Month, Day, Year) MAY 15 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Mahadeb Basu Mahadev Basu</u>				2. DATE OF DEATH MONTH <u>May</u> DAY <u>12</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>4:30 P.</u> M	
4. SOCIAL SECURITY NUMBER <u>217-66-3872</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>54</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>October 2, 1940</u>	
9a. FACILITY NAME (If not Institution, give street and number) <u>5938 Prince George Street</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Catonsville</u>		9c. COUNTY OF DEATH <u>Baltimore</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Baltimore</u>		10c. CITY, TOWN OR LOCATION <u>Catonsville</u>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <u>5938 Prince George Street</u>				10f. ZIP CODE <u>21207</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>Indian</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>3</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Machinist</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Manufacturing Engineer Parts</u>	
17. FATHER'S NAME (First, Middle, Last) <u>Jaladhar Rose</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Ushabala Biswas</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Surja Basu (son)</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1523 Kirkwood Road Baltimore, Maryland 21207</u>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Carroll Cremation Services May 14, 1995 Hampstead, Maryland</u>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>K. Gray Witzke</u>				22. NAME AND ADDRESS OF FACILITY <u>Leroy M. &amp; Russell C. Witzke Funeral Homes 1630 Edmondson Avenue Catonsville, Maryland 21228</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		<u>Cardiomyopathy</u>					Approximate Interval Between Onset and Death <u>10 months</u>
		DUE TO (OR AS A CONSEQUENCE OF):					
		<u>Coronary artery disease</u>					<u>7 yrs.</u>
		DUE TO (OR AS A CONSEQUENCE OF):					
		<u>Hypertension</u>					<u>7 yrs.</u>
		DUE TO (OR AS A CONSEQUENCE OF):					
		<u>Diabetes mellitus - End Stage Renal Disease</u>					<u>&gt; 5 YRS.</u>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Sp. Open Heart Surgery - CABG</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>N Rao MD</u>				29c. LICENSE NUMBER <u>D25483</u>		29d. DATE SIGNED (Month, Day, Year) <u>5/13/95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>NEENA RAO MD 5310 OLD COURT RD, RANDALLSTOWN MD. #301 21133.</u>							
31. DATE FILED (Month, Day, Year) <u>MAY 15 1995</u>				32. REGISTRAR'S SIGNATURE <u>John Andrew Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Thelma K. Beavers</u>				2. DATE OF DEATH MONTH <u>May</u> DAY <u>10</u> YEAR <u>95</u>		3. TIME OF DEATH <u>0915A</u>	
4. SOCIAL SECURITY NUMBER <u>234-74-8749</u>		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>80</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>MAY 2, 1915</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>NORTHWEST MEDICAL CENTER</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>RANDALLSTOWN</u>		9c. COUNTY OF DEATH <u>BALTIMORE</u>	
10a. STATE <u>MD.</u>		10b. COUNTY <u>BALTIMORE</u>		10c. CITY, TOWN OR LOCATION <u>RANDALLSTOWN</u>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <u>4 ADRIANNE COURT</u>				10f. ZIP CODE <u>21133</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>WHITE</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>11</u> College (1-4 or 5+) <u></u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>HOMEMAKER</u>		16b. KIND OF BUSINESS/INDUSTRY <u>OWN HOME</u>			
17. FATHER'S NAME (First, Middle, Last) <u>DAVID CROCKETT HURLEY</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>EARLY SMITH</u>			
19a. INFORMANT'S NAME (Type/Print) <u>LOYD J. BEAVERS</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4 ADRIANNE COURT RANDALLSTOWN, MD 21133</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>GRANDVIEW MEM. GARDENS #1445</u>		20c. LOCATION — City or Town, State <u>BLUEFIELD, VA.</u>		20d. DATE <u>5</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Thomas J. Akande Jr.</u>				22. NAME AND ADDRESS OF FACILITY <u>SKARDA FH. 2829 HUDSON ST. BALTO., MD - 21224</u>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>Respiratory failure</u> DUE TO (OR AS A CONSEQUENCE OF):				Approximate interval between Onset and Death <u>18 days</u>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. <u>emphysema</u> DUE TO (OR AS A CONSEQUENCE OF):				prior	
		c. <u>pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF):				8 days	
		d. <u>renal failure</u> DUE TO (OR AS A CONSEQUENCE OF):				5 days	
		PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>congestive heart failure</u> <u>coronary artery disease</u>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <u>Alice S. Hirsch</u>		29c. LICENSE NUMBER <u>H43974</u>		29d. DATE SIGNED (Month, Day, Year) <u>May 10, 95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Hirsch, Alice Northwest Hospital, Randallstown, Md</u>							
31. DATE FILED (Month, Day, Year) <u>MAY 15 1995</u>		32. REGISTRAR'S SIGNATURE <u>Jane Wheeler Randall</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be delivered to the funeral-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14698

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CATHERINE CHELL</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>3</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>1:30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>215-09-8099</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT 20 1909</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>SUMMIT NURSING HOME</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>CATONSVILLE</b>		8c. COUNTY OF DEATH <b>BALTIMORE</b>	
9a. STATE <b>Maryland</b>		9b. COUNTY <b>Baltimore</b>		9c. CITY, TOWN OR LOCATION <b>Baltimore</b>		9d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10a. STREET AND NUMBER <b>3 Dutton Avenue</b>				10f. ZIP CODE <b>21228</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Executive Secretary</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Manufacturer</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Edward John Chell</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Catherine Doll</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Naomi Hardman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8125 Glen Gary Rd., Balto., MD 21234</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir.</i>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board 655 West Baltimore St., Balto., MD 21201</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Dementia</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): <b>Dementia</b> b. DUE TO (OR AS A CONSEQUENCE OF): <b>Dementia</b> c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>5 yrs.</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D26294</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/9/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>LUIS ZUNIGA, MD, 1101 MAIDEN CHOICE LANE, BALTIMORE MD 21229</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14699

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Catherine Coyle</i>				2. DATE OF DEATH MONTH DAY YEAR <i>May 11 1995</i>		3. TIME OF DEATH M <i>1:15 P</i>	
4. SOCIAL SECURITY NUMBER <i>216-09-1056</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>90 YRS.</i>		7. DATE OF BIRTH (Month, Day, Year) <i>March 19, 1909</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Charlestown Care Center, 701 Maiden Choice LA. Baltimore</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>	
9c. COUNTY OF DEATH				10a. STATE <i>Maryland</i>		10b. COUNTY	
10c. CITY, TOWN OR LOCATION <i>Baltimore</i>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>711 Maiden Choice Lane #2214</i>	
10f. ZIP CODE <i>21228</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Executive Secretary</i>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <i>John Farrell</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Katharine C. DeBoy</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Patrick Farrell</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2 Wynnewood Court, Baltimore, MD 21227</i>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir.</i>				22. NAME AND ADDRESS OF FACILITY <i>State Anatomy Board 655 West Baltimore St., Balto., MD 21201</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Chronic Obstructive Pulmonary Disease 20 yrs</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>ASXhma</i> b. c. d. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gary Applebaum MD</i>				29c. LICENSE NUMBER <i>D34053</i>		29d. DATE SIGNED (Month, Day, Year) <i>May 11, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Gary Applebaum MD 711 Maiden Choice Lane 21228</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 15 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Division-Rodell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14700

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Earl Forbes Cox, Jr.				2. DATE OF DEATH MONTH DAY YEAR May 10, 1995		3. TIME OF DEATH 10:35 PM	
4. SOCIAL SECURITY NUMBER 197-28-7947		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 14, 1937	
9a. FACILITY NAME (If not institution, give street and number) 2439 Braddock Road				9b. CITY, TOWN OR LOCATION OF DEATH Mt. Airy		9c. COUNTY OF DEATH Carroll	
10a. STATE Maryland				10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Mt. Airy	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 2439 Braddock Road				10f. ZIP CODE 21771		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+) 12 years				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner-President Forbes Co.		15b. KIND OF BUSINESS/INDUSTRY Direct (Mail) Marketing	
17. FATHER'S NAME (First, Middle, Last) Earl F. Cox, Sr.				16. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie Glass			
19a. INFORMANT'S NAME (Type/Print) Mrs. Brenda M. Cox				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2439 Braddock Road Mt. Airy, MD 21771			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Peter's Ch. Cemetery		DATE 5/15		20c. LOCATION — City or Town, State Libertytown, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James B. Covey				22. NAME AND ADDRESS OF FACILITY Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC squamous cell carcinoma to lung DUE TO (OR AS A CONSEQUENCE OF): b. X DUE TO (OR AS A CONSEQUENCE OF): c. X DUE TO (OR AS A CONSEQUENCE OF): d. X Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death 4/95 (6 weeks)
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC ACTIVE HEPATITIS							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Thomas K. Galvin III MD				29c. LICENSE NUMBER D31660		29d. DATE SIGNED (Month, Day, Year) 5/12/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) T. K. GALVIN III, M.D. 342 Washington Rd #104 Westminster, MD 21157							
31. DATE FILED (Month, Day, Year) MAY 15 1995				32. REGISTRAR'S SIGNATURE John Anderson-Rodell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FilmG, 723, item #1, 9b, 5/15/95, cyw, f.h.

95 14701

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LOUIS STEPHEN LEWIS CHEARNO</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 8, 1995</b>		3. TIME OF DEATH <b>1:10 P M</b>	
4. SOCIAL SECURITY NUMBER <b>179-10-0426</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 27, 1910</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>#1 GERMAN HILL ROAD</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>ESSEX DUNDALK</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Dundalk</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1 German Hill Road</b>	
10f. ZIP CODE <b>21222</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8 Years</b> College (14 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Chef</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Food Industry</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John Chearno</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rose DeMeo</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Rocco Chearno</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>206 D Chaucer Lane Bel Air, MD 21014</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gans of Faith Cem. May 12, 1995</b>		20c. LOCATION — City or Town, State <b>Rossville, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Chad W. Lush</i>				22. NAME AND ADDRESS OF FACILITY <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald G. Wright MD</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 9, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>THEODORE M. KING M.D. 111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

PHOTO 2

PHOTO 3

PHOTO 4

PHOTO 5



95 14702

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>PEARL CLARK</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>7</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>11:15P M</b>	
4. SOCIAL SECURITY NUMBER <b>219-28-7671</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec 10 1907</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Lorien Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Columbia</b>		9c. COUNTY OF DEATH <b>Howard</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>432 E. Lorraine St.</b>				10f. ZIP CODE <b>21218</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Outside Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>James Harris</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Susie Johnson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Edna Green</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>432 E. Lorraine St. Balto. Md. 21218</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, church, or other place) <b>MT. ZION</b>		20c. LOCATION — City or Town, State <b>5/12/95 Lansdowne, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Joseph L. Russ</b>				22. NAME AND ADDRESS OF FACILITY <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Urosepsis</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Urinary retention</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>dementia - Alzheimer's type</b> DUE TO (OR AS A CONSEQUENCE OF): d.  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>Acute</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Ruford Holmberg</b>				29c. LICENSE NUMBER <b>D31575</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 12/1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>KOLODRUBETZ 8501 Old Annapolis Rd Ellicott City MD 21043</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Andrew Parrott</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14703

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jane Frances Cole				2. DATE OF DEATH MONTH DAY YEAR May 10, 1995		3. TIME OF DEATH 6:15 a m					
4. SOCIAL SECURITY NUMBER 214-58-8169		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 45 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug 16, 1949		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) 3716 Old Milford Mill Road				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore			9c. COUNTY OF DEATH Baltimore				
RESIDENCE OF DECEDENT				10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 3716 Old Milford Mill Road		10f. ZIP CODE 21244		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 Year		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Own Home							
17. FATHER'S NAME (First, Middle, Last) Ambrose R. Cremen, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy A. Swach							
19a. INFORMANT'S NAME (Type/Print) Mr. William L. Cole				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3716 Old Milford Mill Road Baltimore, MD 21244							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lake View Memorial Park 5/13		20c. LOCATION — City or Town, State Sykesville, MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen M. Jenkins</i>				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Neoplasm Brain.</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate interval Between Onset and Death 5 yrs.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M			
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. SIGNATURE AND TITLE OF CERTIFIER <i>Hermon Byers M.D.</i>		29c. LICENSE NUMBER D01317		29d. DATE SIGNED (Month, Day, Year) 5/11/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Hermon Byers, M.D.											
31. DATE FILED (Month, Day, Year) MAY 15 1995		32. REGISTRAR'S SIGNATURE <i>John B. ...</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GEORGE WILLIAM CARSTENS III				2. DATE OF DEATH MONTH DAY YEAR MAY 11, 1995		3. TIME OF DEATH 14:11 P M									
4. SOCIAL SECURITY NUMBER 216-44-4647		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 50 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 14, 1944		8. BIRTHPLACE (State or Foreign Country) MD.							
9a. FACILITY NAME (If not institution, give street and number) SUBURBAN HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda			9c. COUNTY OF DEATH MONTGOMERY								
10a. STATE MD.		10b. COUNTY Baltimore Co.		10c. CITY, TOWN OR LOCATION Baltimore			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								
10e. STREET AND NUMBER 142 Stevenson Lane				10f. ZIP CODE 21212		10g. CITIZEN OF WHAT COUNTRY? U.S.A.									
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE - American Indian, Black, White, etc. Specify: White								
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver		16b. KIND OF BUSINESS/INDUSTRY Charlie Plitts Seafood											
17. FATHER'S NAME (First, Middle, Last) George William Carstens II				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Rykowski											
19a. INFORMANT'S NAME (Type/Print) Regina R. Murphy				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6652 Loch Hill Rd. Baltimore, MD. 21239											
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Methu Crematory		20c. LOCATION - City or Town, State Methu Catonsville MD.		20d. DATE May 11, 1995									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn P. Chaffin				22. NAME AND ADDRESS OF FACILITY Chapman E.H. 2007 Eastern Ave 21231											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE INJURIES DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 5 11 95		28b. TIME OF INJURY 1256P M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED DRIVER OF CAR STRUCK BY TRUCK							
28e. PLACE OF INJURY - A1 home, farm, street, factory, office building, etc. (Specify) ROADWAY				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) SEVEN LOCKS RD BALTIMORE CO. MD											
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												29c. LICENSE NUMBER OCME		29d. DATE SIGNED (Month, Day, Year) MAY 12, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MADONNA A. KORON MD. 111 Penn Street, Baltimore, Maryland 21201															
31. DATE FILED (Month, Day, Year) MAY 15 1995												32. REGISTRAR'S SIGNATURE John [Signature]			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR



768-1380 - Dr. Reid

95 14705

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Herbert C Cox</u>				2. DATE OF DEATH MONTH <u>5</u> DAY <u>9</u> YEAR <u>95</u>		3. TIME OF DEATH <u>5:15P</u> M	
4. SOCIAL SECURITY NUMBER <u>212-07-1881</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>94</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>4-24-01</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>							
9a. FACILITY NAME (If not institution, give street and number) <u>Chapel Hill Convalescent Center</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Randallstown</u>		9c. COUNTY OF DEATH <u>Baltimore</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>Md.</u>		10b. COUNTY <u>Baltimore</u>		10c. CITY, TOWN OR LOCATION <u>Baltimore</u>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <u>2105 Woodbourne Avenue</u>				10f. ZIP CODE <u>21214</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>white</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>H.S.</u> College (1-4 or 5+) <u>---</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>supervisor A&amp;P</u>		16b. KIND OF BUSINESS/INDUSTRY <u>grocery</u>			
17. FATHER'S NAME (First, Middle, Last) <u>John E. Cox</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Emma C. unknown</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Kenneth L. Nerim</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>7003 Beachmont Dr. Sykesville, Md. 21784</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Woodlawn Cemetery</u>		DATE <u>5-12-95</u>		20c. LOCATION — City or Town, State <u>Baltimore, Md.</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Brian D. Haight</u>				22. NAME AND ADDRESS OF FACILITY <u>Haight Funeral Home</u> <u>Box 195 Sykesville, Md. 21784</u>			
23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <u>Respiratory Failure</u> DUE TO (OR AS A CONSEQUENCE OF):							
b. <u>Recent pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Approximate Interval Between Onset and Death <u>3 weeks</u> <u>3 weeks</u>							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>probable Lung Tumor</u> <u>History of prostate tumor.</u> <u>And emphysema</u>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u> M.D.				29c. LICENSE NUMBER <u>D-22609</u>		29d. DATE SIGNED (Month, Day, Year) <u>5/11/95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>ROBEN REIDER M.D.</u> <u>7445 FURNACEBRANCH Rd - Glen Burne</u>							
31. DATE FILED (Month, Day, Year) <u>MAY 15 1995</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u> Md 21060.			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21.2.1968, 20.6.1968



95 14706

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Louis J. Di Stefano</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>13</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>6:00 A M</b>	
4. SOCIAL SECURITY NUMBER <b>220-22-3796</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 28, 1928</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Baltimore, Md.</b>		9a. FACILITY NAME (If not institution, give street and number) <b>5006 Ross Road</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>5006 Ross Road</b>		10f. ZIP CODE <b>21214</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W.W.II</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Tile &amp; Terrazzo</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Masonry</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Napoleon Di Stefano</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ida Fiorentino</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Mary Basso</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3629 Templar Road, Randallstown, Maryland 21133</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest Vet. Cem. 5-17-95</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Jeffrey L. Jain</b>				22. NAME AND ADDRESS OF FACILITY <b>Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21204</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>acute myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>ASCVD</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Frank S. Palmisano, Jr., M.D.</b>				29c. LICENSE NUMBER <b>D09475</b>		29d. DATE SIGNED (Month, Day, Year) <b>5-15-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FRANK S. PALMISANO, JR., M.D.</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <b>Julia Howard-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14707

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Lucretia Daniels</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 3 1995</b>		3. TIME OF DEATH <b>8:15p M</b>	
4. SOCIAL SECURITY NUMBER <b>214-40-4903</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>99 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>August 27, 1897</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Harford Nursing Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10a. STREET AND NUMBER <b>827 Arlington Ave. #711</b>				10f. ZIP CODE <b>21217</b>		10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald Wade, Dir.</b> <i>Ronald Wade 5/1/95</i>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board</b> <b>655 West Baltimore St., Balto., MD 21201</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic coronary artery disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Miriam Kamil</i>				29c. LICENSE NUMBER <b>15210 22</b>		29d. DATE SIGNED (Month, Day, Year) <b>5-9-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>H. KOWALEWSKY 8604 HARFORD RD 21234</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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Item 10b, 9-723, 5-15-95, per f.h., dk

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BERNARD Diggs</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 11, 1995</b>				3. TIME OF DEATH M <b>12:41p</b>			
4. SOCIAL SECURITY NUMBER <b>219-30-5433</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>58 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>9-30-36</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>3901 Amy Lane</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Randallstown</b>				9c. COUNTY OF DEATH <b>Baltimore</b>			
RESIDENCE OF DECEDENT											
10a. STATE <b>MD</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Randallstown</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>3901 Amy Lane</b>				10f. ZIP CODE <b>21133</b>			10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Self Employed</b>			15b. KIND OF BUSINESS/INDUSTRY <b>Commercial Cleaner</b>				
17. FATHER'S NAME (First, Middle, Last) <b>Samuel Diggs</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Irma Ross</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Rita Stewart</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3901 Amy Lane Balto., MD 21133</b>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus Memorial Pk</b>		DATE <b>5/15</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James A. Morton</b>				22. NAME AND ADDRESS OF FACILITY <b>JAMES A. MORTON &amp; SONS 2127 1701 LAWRENCE ST. BALTO MD</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>sepsis &amp; coma</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <b>As a result of decompensation</b> <b>exacerbated ulcer &amp; GI bleed</b> <b>AIDS</b>								Approximate Interval Between Onset and Death <b>3d</b> <b>1 mo</b> <b>2 mo</b> <b>4 yr</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORKS 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Michael Steen MD</b>				29c. LICENSE NUMBER <b>MO5224</b>			29d. DATE SIGNED (Month, Day, Year) <b>5/16/95</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <b>4000 Old Court Road Suite 200, Baltimore, MD</b>											
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <b>John A. ...</b>							

BALTIMORE, MARYLAND-21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 687600

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be returned to the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.




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95 14709

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JEANETTE A. DYKMAN</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>10</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>9:30 PM</b>	
4. SOCIAL SECURITY NUMBER <b>219-18-5771</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 6 1924</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>UNION MEMORIAL HOSPITAL</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		8c. COUNTY OF DEATH	
9a. RESIDENCE OF DECEDENT 10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Timonium</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>303 Jodyway</b>				10f. ZIP CODE <b>21093</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Vice President</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Banking</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William Anthon</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lula Yeagle</b>			
19a. INFORMANT'S NAME (Type/Print) <b>William Dykman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>303 Jodyway Timonium Md. 21093</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Druid Ridge Cemetery 5-13-95</b>		20c. LOCATION — City or Town, State <b>Pikesville Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Ruck Towson F.H. 1050 York Rd. Towson Md. 21204</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>glioblastoma of the brain</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>5 months</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				29a. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29b. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29c. SIGNATURE AND TITLE OF CERTIFIER  — M.D.				29d. LICENSE NUMBER <b>646574</b>		29e. DATE SIGNED (Month, Day, Year) <b>5/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ANDREW B. REISMAN, M.D. UNION MEMORIAL HOSPITAL</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14710

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ella May Dorsey				2. DATE OF DEATH MONTH DAY YEAR May 11 1995		3. TIME OF DEATH 9:30 a m	
4. SOCIAL SECURITY NUMBER 269-14-0253		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 96 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 22, 1898	
9a. FACILITY NAME (If not institution, give street and number) Dulaney Towson Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Towson		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 111 West Rd.				10f. ZIP CODE 21204		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 yrs		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Charles Gittings				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Litsinger			
19a. INFORMANT'S NAME (Type/Print) Mary E. Stokely				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 180 Taiwan Island Rd. Leesburg, Fl. 34788			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery		DATE 5-15		20c. LOCATION — City or Town, State Parkville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Acute Myocardial Infarct</i> DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death <i>Instant</i>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. <i>Atherosclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF):				6 years	
		c. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 					
		29c. LICENSE NUMBER D12039		29d. DATE SIGNED (Month, Day, Year) MAY 11, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Welzant 7600 Osler Dr. Suite 107 Towson Md. 21204							
31. DATE FILED (Month, Day, Year) MAY 15 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14711

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EVELYN DANIELS</b>				2. DATE OF DEATH MONTH <b>5</b> DAY <b>12</b> YEAR <b>95</b>		3. TIME OF DEATH <b>9 A</b>	
4. SOCIAL SECURITY NUMBER <b>216-12-6802</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2-27-07</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Sinai</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>n/a</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>n/a</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1154 Longwood St.</b>	
10f. ZIP CODE <b>21216</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unk.</b> College (1-4 or 5+) <b>unk.</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Machinist</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Government</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Eugene Brown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ardella Hughes</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Nancy Barrick</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9385 Diamond Back Rd. Columbia, MD 21045</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Lukes Metropolitan 5/17 Baltimore, MD</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James A. Morton</i>				22. NAME AND ADDRESS OF FACILITY <b>James A. Morton &amp; Sons Funeral Homes 1701 Laurens St. Balto., MD 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>METASTATIC GASTRIC Cancer</b>							
Due to (or as a consequence of): <b>Respiratory Arrest</b>							
Due to (or as a consequence of): <b>BREAST Cancer</b>							
Due to (or as a consequence of):							
Due to (or as a consequence of):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>AAA Repair, HTN,</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>John HAKIM MD</b>				29c. LICENSE NUMBER <b>2402321JH9852</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/12/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John HAKIM MD, Sinai Hospital of Baltimore</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14712

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DAUSINGER, CHARLOTTE</b>				2. DATE OF DEATH MONTH <b>5</b> - DAY <b>9</b> - YEAR <b>95</b>		3. TIME OF DEATH <b>6:45 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>219 20 2004</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 19, 1908</b> Md.	
8a. FACILITY NAME (If not institution, give street and number) <b>Sykesville Eldee-Care</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Sykesville</b>		8c. COUNTY OF DEATH <b>Carroll</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Carroll</b>		10c. CITY, TOWN OR LOCATION <b>Sykesville</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7310 Gaither Rd.</b>				10f. ZIP CODE <b>21784</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>High School</b> College (14 or 5+) <b>+2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Nurse Licensed Practical</b>		16b. KIND OF BUSINESS/INDUSTRY <b>State Hospital</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Charles Henry</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Minnie Unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>David Kartalia</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>133 E. Main St. Westminster, Md. 21157</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Evergreen Mem. Gardens</b>		20c. LOCATION — City or Town, State <b>5-13-95 Finksburg, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Harry W. Haight</b>				22. NAME AND ADDRESS OF FACILITY <b>Haight Funeral Home P.O. Box 195 Sykesville, Md. 21784</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardio-Pulmonary failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Right lower lobe pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Chronic Obstructive lung disease.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Chronic atrial fibrillation.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pre-renal azotemia.</b> <b>S/P Left cerebrovascular accident</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Leon Flemebaum, MD</b>				29c. LICENSE NUMBER <b>D35372</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 12/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Leon Flemebaum, MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>		32. REGISTRAR'S SIGNATURE <b>John Andrew Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

WILLIAM B. BROWN

WILLIAM B. BROWN

WILLIAM B. BROWN

95 14713

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BARBARA N. EBB				2. DATE OF DEATH MONTH DAY YEAR MAY 9, 1995				3. TIME OF DEATH 20:57 P M	
4. SOCIAL SECURITY NUMBER 216-34-7074		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 57 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) MARCH 28 1938 MD	
9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTO				9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT									
10a. STATE MD		10b. COUNTY BALTO		10c. CITY, TOWN OR LOCATION CATONSVILLE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 24 MAINE AVE				10f. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: BLACK		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4 or 5+) N/A			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MAINTENANCE WORKER			16b. KIND OF BUSINESS/INDUSTRY U.M.B.C.			
17. FATHER'S NAME (First, Middle, Last) ANTHONY W. NELSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) MILDRED JENIFER					
19a. INFORMANT'S NAME (Type/Print) YVONNE M. EVANS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5876 DEER RIDGE LANE ELKRIDGE MD @21227					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, etc. (Type/Print)) GARRISON FOREST VET 51695		DATE MAY 9 1995		20c. LOCATION — City or Town, State OWINGS MILLS MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Yvonne M. Evans</i>				22. NAME AND ADDRESS OF FACILITY MARCH F/H-WEST 4300 WABASH AVE					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Atherosclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Diabetes Mellitus</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Hypertension</i> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 1 yr 20 yrs 20 yrs	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> PER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kevin H. Scruggs</i>				29c. LICENSE NUMBER D38543		29d. DATE SIGNED (Month, Day, Year) MAY 9, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KEVIN H. SCRUGGS MD 900 CATON AVENUE BALTIMORE 21229									
31. DATE FILED (Month, Day, Year) MAY 15 1995		32. REGISTRAR'S SIGNATURE <i>Jahia A. Anderson-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14714

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

May REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY E FORDER</b>				2. DATE OF DEATH MONTH <b>5</b> DAY <b>7</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>0858AM</b>	
4. SOCIAL SECURITY NUMBER <b>216-10-4274</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Mar 9, 1917</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Northwest Hospital Center</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Randallstown</b>		8c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Randallstown</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>9051 Allenswood Road</b>				10f. ZIP CODE <b>21133</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1 Year</b> College (1-4 or 5+) <b>Bookkeeper</b>				16. KIND OF BUSINESS/INDUSTRY <b>McDonough School</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Louis A. Rand</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Moorehead</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Ralph Winter Forder</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9051 Allenswood Road Randallstown, Maryland 21133</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery 5/11</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen M. Jenken</i>				22. NAME AND ADDRESS OF FACILITY <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiogenic Shock</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <b>Acute inferolateral wall Reinfarction</b> DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <b>12 hrs</b> <b>24 hrs</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypercholesterolemia</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY <b>M</b>		26c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		26d. DESCRIBE HOW INJURY OCCURRED		26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Haleez A Syed</b>				29c. LICENSE NUMBER <b>D25052</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 7 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Haleez A Syed 20 Cross Roads Dr Owings Mills</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

*[Faint handwritten notes at the bottom of the page]*

95-2760-005

DWG

95 14715

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HUGH G. FREEMAN</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>12</b> YEAR <b>95</b>		3. TIME OF DEATH <b>10:30A M</b>	
4. SOCIAL SECURITY NUMBER <b>212-32-3958</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 31, 1913</b>	
9a. FACILITY NAME (If not Institution, give street and number) <b>14317 OLD HANOVER ROAD</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Boring</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Boring</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>14317 Old Hanover Rd.</b>				10f. ZIP CODE <b>21020</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Owner</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Taxi Cab Co.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Edward A. Freeman</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ora Smith</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Annette Freeman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14317 Old Hanover Rd., Boring, Md. 21020</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Druid Ridge Cem. May 15, 1995</b>		20c. LOCATION — City or Town, State <b>Pikesville, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>H. E. Eckhardt</i>				22. NAME AND ADDRESS OF FACILITY <b>Eckhardt Funeral Chapel 21117 11605 Reisterstown Rd., Owings Mills, Md</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				INSPECTION			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Margaret Korell M.D.</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 12/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARGARITA KORELL M.D. 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b> <i>J. A. [Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14716

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HAROLD E GARRISON				2. DATE OF DEATH MONTH DAY YEAR MAY 7, 1995		3. TIME OF DEATH 4:00 AM	
4. SOCIAL SECURITY NUMBER 579-22-7879		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 5, 1914	
9a. FACILITY NAME (If not institution, give street and number) Prince Georges Hosp., 6501 Landover Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince Georges	
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Colmar Manor		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4303 Monroe St.				10f. ZIP CODE 20722		10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir. <i>Ronald Wade</i> 5/1/95				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 West Baltimore St., Balto., MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Sepsis</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <i>7-10 Days</i> <i>10 Days</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Portaled gastric ulcer; H/o prostate cancer; H/o cerebral vascular accident</i>							24b. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24d. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Villanor S. Reyes M.D.</i>		29c. LICENSE NUMBER D29671		29d. DATE SIGNED (Month, Day, Year) 5/7/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VILLANOR S. REYES, M.D. 6501 LANDOVER RD CHEVERLY MD 20785							
31. DATE FILED (Month, Day, Year) MAY 15 1995		32. REGISTRAR'S SIGNATURE <i>John D. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14717

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EARL GANTT</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>9</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>1:45P</b> M	
4. SOCIAL SECURITY NUMBER <b>213-30-8928</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>60</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 30, 1935</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Perry Point Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Perryville</b>		9c. COUNTY OF DEATH <b>Cecil County</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>n/a</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1613 Dukeland Street</b>			
10f. ZIP CODE <b>21216</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Jan '55 - Jan '59</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>High School</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Disabled Veteran</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Government</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Joseph A. Gantt</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Edna Cartwell</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Frances Dawson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3309 Alto Road Baltimore, Maryland 21216</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MD Veteran Cemetery/Garrison May 15</b>		20c. LOCATION — City or Town, State <b>Owings Mills, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edna Cartwell</i>				22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. SEPSIS PROBABLY DUE TO ASPIRATION PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MULTI INFARCT DEMENTIA, END STAGE</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							24c. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Elisabeth Sethi</i>				29c. LICENSE NUMBER <b>D 33177</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/9/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ELISABETH SETHI, M.D., VA MEDICAL CENTER PERRY POINT MD 21902</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MEDICAL



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

1. DECEDENT'S NAME (First, Middle, Last) <b>Esther Julia Geare</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>11</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>6:25 p.m.</b>					
4. SOCIAL SECURITY NUMBER <b>219-03-7841</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 9, 1905</b>		8. BIRTHPLACE (State or Foreign Country) <b>Md.</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>Stella Maris Hospice</b>					9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>				9c. COUNTY OF DEATH <b>Baltimore</b>				
RESIDENCE OF DECEDENT													
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>			10c. CITY, TOWN OR LOCATION <b>Timonium</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER <b>16 Bandon Ct.</b>					10f. ZIP CODE <b>21093</b>			10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>House Wife</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>					
17. FATHER'S NAME (First, Middle, Last) <b>John Wehner</b>					18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Gertrude UnKnown</b>								
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Clifford Geare, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16 Bandon Ct. Timonium, Md. 21093</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Most Holy Redeemer Cem. 5/13/95</b>				DATE <b>5/13/95</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 					22. NAME AND ADDRESS OF FACILITY <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Myocardial Infarction</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <b>Myocardial Infarction</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Artery Disease</b>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 3 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 					29c. LICENSE NUMBER <b>15504</b>			29d. DATE SIGNED (Month, Day, Year) <b>May 15 1995</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <b>John Wehner 16 Bandon Ct. Towson, Md. 21204</b>													
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>													



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ARBUTUS B. GARDNER</b>				2. DATE OF DEATH MONTH <b>5</b> DAY <b>11</b> YEAR <b>95</b>		3. TIME OF DEATH <b>6:30 am</b> M	
4. SOCIAL SECURITY NUMBER <b>215-05-1730</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept 24, 1914</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Westminster Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Westminster</b>	
9c. COUNTY OF DEATH <b>Carroll</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Carroll</b>	
10c. CITY, TOWN OR LOCATION <b>Westminster</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1234 Washington Road</b>	
10f. ZIP CODE <b>21157</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Worked for Balto. County</b>		16b. KIND OF BUSINESS/INDUSTRY <b>School Bus Driver</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Charles Z. Lohoefer</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marquerite Boidy</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Robert W. Gardner</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3232 Magnolia Avenue English Consul Balto. MD 21227</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery 5/13 Baltimore, MD</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen M. Jenkins for Burrier-Queen</i>				22. NAME AND ADDRESS OF FACILITY <b>Burrier-Queen Funeral Directors, P.A. 21784 1212 West Old Liberty Road Winfield, MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiorespiratory Arrest</b> DUE TO (OR AS A CONSEQUENCE OF): <b>ASCVD, CHF, Previous Myocardial infarction. valvular H. disease.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Essentially end-stage heart disease - Cardiomyopathy.</b> Approximate Interval Between Onset and Death Time <b>5:45 AM 5-11-95</b> <b>6:30 AM 5-11-95 EXPIRED (45 minutes)</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>1) Same as above. 2) In addition PVD - Pre-gangrenous Toes.</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Farzad Assar, M.D.</i>				29c. LICENSE NUMBER <b>D-40201</b>		29d. DATE SIGNED (Month, Day, Year) <b>5-11-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type/Print) <b>FARZAD ASSAR, M.D. 1502 S. MAIN ST. MT AIRY 21771</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b> John [Signature] REGISTRAR'S SIGNATURE							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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FilmG, 723, item #1, 5/15/95, cyw, per f.h.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Lillian Mary Horst</i>				2. DATE OF DEATH MONTH <i>5</i> DAY <i>12</i> YEAR <i>95</i>		3. TIME OF DEATH <i>9:35 PM</i>	
4. SOCIAL SECURITY NUMBER <i>215-48-3462</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>97</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>12-14-97</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Mendham, N.H., 1801 Wentworth Rd.</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore, Md 21234</i>		9c. COUNTY OF DEATH <i>Baltimore</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>N/A</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>6309 Fair Oaks Avenue</i>				10f. ZIP CODE <i>21214</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9</i> College (1-4 or 5+) <i></i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>N/A</i>			
17. FATHER'S NAME (First, Middle, Last) <i>William Everett Land</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Lillie Neu</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Marilyn H. Taschenberg</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6309 Fair Oaks Avenue Baltimore, Md. 21214</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Parkwood Cemetery</i>		20c. LOCATION — City or Town, State <i>5/16/95 Baltimore, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jeffrey L. Fair</i>				22. NAME AND ADDRESS OF FACILITY <i>Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Ischemic Heart Disease</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Refractory Atrial Fibrillation</i> <i>Chronic Renal Failure</i>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Refractory Atrial Fibrillation</i> <i>Chronic Renal Failure</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Patricia V. Patterson MD</i>				29c. LICENSE NUMBER <i>D08358</i>		29d. DATE SIGNED (Month, Day, Year) <i>5/13/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Patricia V. Patterson MD</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 15 1995</i>		32. REGISTRAR'S SIGNATURE <i>Dr. William Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14721

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOHN G. HUNTER, JR.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 8, 1995</b>		3. TIME OF DEATH <b>S.A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>213-28-4724</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>64</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JAN 24, 1931</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>612 FOXCROFT DRIVE</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>BLAIR</b>		8c. COUNTY OF DEATH <b>HARFORD</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>HARFORD</b>		10c. CITY, TOWN OR LOCATION <b>BLAIR</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>612 FOXCROFT DRIVE</b>			
10f. ZIP CODE <b>21014</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>KOREA</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YRS.</b> College (1-4 or 5+) :				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SALES</b>		16b. KIND OF BUSINESS/INDUSTRY <b>LUMBER</b>	
17. FATHER'S NAME (First, Middle, Last) <b>JOHN G. HUNTER, SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>HELEN PHILPOT</b>			
19a. INFORMANT'S NAME (Type/Print) <b>GERTRUDE M. HUNTER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>612 FOXCROFT DRIVE BLAIR, MARYLAND 21014</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BLAIR MEMORIAL GARDENS 5-10</b>		20c. LOCATION — City or Town, State <b>BLAIR MARYLAND</b>		20d. DATE <b>5-10</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>EVANS FUNERAL CHAPEL - BLAIR, P.A. 21010</b> <b>3 NEWPORT DRIVE FOREST HILL, MARYLAND</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>A. ADENOCARCINOMA of LUNG</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify):		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D 31775</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 9, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. JOAN P. EDWARDS 2112 BLAIR ROAD - FALLSTON, MARYLAND 21047</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14722

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Robert Hollins</b>				2. DATE OF DEATH MONTH <b>5</b> DAY <b>09</b> YEAR <b>95</b>		3. TIME OF DEATH <b>5:30 PM</b>	
4. SOCIAL SECURITY NUMBER <b>250-03-2569</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-25-1910</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>BON SECOURS Hospital</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		8c. BIRTHPLACE (State or Foreign Country) <b>Sumter, South Carolina</b>	
9a. RESIDENCE OF DECEDENT				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>NA</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>NA</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>407 Lynhurst street</b>				10f. ZIP CODE <b>21229</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10TH Grade</b> College (1-4 or 5+) <b>NA</b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SHIP WORKER</b>		17. KIND OF BUSINESS/INDUSTRY <b>Contracting</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Robert Hollins SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rena Hollins</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mattie James</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>407 Lynhurst St. Baltimore, Md. 21229</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>mt. ZION CEMETERY</b>		20c. DATE <b>5-13</b>		20d. LOCATION — City or Town, State <b>Lansdowne, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Nancy M. Wallace</b>				22. NAME AND ADDRESS OF FACILITY <b>Nancy M. Wallace Funeral Service 3405 W. Franklin St. Balto, Md. 21229</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Renal Failure</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>7 day</b> <b>1 month</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal Failure</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER <b>Attending</b>				29c. LICENSE NUMBER <b>025046</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/15/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>M. Robinson 2717 Hammock Road 21227</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>		32. REGISTRAR'S SIGNATURE <b>John A. ...</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14723

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>John David Henderson</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 11, 1995</b>		3. TIME OF DEATH <b>4:45 AM</b>	
4. SOCIAL SECURITY NUMBER <b>417-22-9642</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 1, 1925</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>7819 St. Gregory Drive</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Dundalk,</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Dundalk</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7819 St. Gregory Drive</b>				10f. ZIP CODE <b>21222</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11 Years</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Steelworker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Steel Industry</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Jesse Henderson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Not Known</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Joseph Henderson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1726 Beechwood Ave. Essex, Maryland 21221</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery 5/13/95</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Chad W. Esch</i>				22. NAME AND ADDRESS OF FACILITY <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Adrenocortical insufficiency</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Metabolic adrenocortical insufficiency</b> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <b>2/3</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John D. Olsen</i>				29c. LICENSE NUMBER <b>D18648</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/11/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>20415 O. JZ SAN IN 1012 220 N. PT. LG. BMT-NEC</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14724

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>William G.M. Hardy, Sr.</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>12</b> YEAR <b>95</b>		3. TIME OF DEATH <b>3:55 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>320-03-1812</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2/27/20</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Good Samaritan Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>N/A</b>				10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>2739 Brendan Avenue</b>			
10f. ZIP CODE <b>21213</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Postal Worker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Postal Service</b>	
17. FATHER'S NAME (First, Middle, Last) <b>James M. Hardy</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Clara Webb</b>			
19a. INFORMANT'S NAME (Type/Print) <b>William G.M. Hardy, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2739 Brendan Avenue Baltimore, MD 21213</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 5/13/95</b>		20c. LOCATION — City or Town, State <b>Catonsville, MD</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY <b>Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21286</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Metastatic cancer to liver primary unknown. 2wk</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>obstructive pulmonary disorder, Diabetes mellitus.</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Lena Sayegh MD.</b>		29c. LICENSE NUMBER <b>P08239</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 12 - 95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Good Samaritan Hospital, 5601 Loch Raven Blvd. Baltimore MD.</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14725

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BETTY HARRISON</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 10, 1995</b>		3. TIME OF DEATH <b>05:10A</b> M	
4. SOCIAL SECURITY NUMBER <b>118 20 8296</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3/27/22</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>N.A.</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD.</b>		10b. COUNTY <b>N.A.</b>		10c. CITY, TOWN OR LOCATION <b>BALTO.</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1206 E. Lafayette Ave</b>				10f. ZIP CODE <b>21202</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Domestic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>PRIVATE FAMILY</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JUNIUS HARRISON</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARINDA STOVALL</b>			
19a. INFORMANT'S NAME (Type/Print) <b>BARBARA. WILLIAMS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1206 E. Lafayette Ave BALTO. MD. 21202</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BALTO. Cem. 5/15</b>		20c. LOCATION — City or Town, State <b>BALTO: MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Joseph M. Lock</b>				22. NAME AND ADDRESS OF FACILITY <b>Locks Funeral Home 1304 N. Central St</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Respiratory failure, cardiogenic shock</b>					Approximate Interval Between Onset and Death <b>24 hr</b>
		b. <b>Intracranial hemorrhage</b>					<b>5d</b>
		c. <b>Congestive heart failure</b>					<b>5 years</b>
		d. <b>Septis</b>					<b>24 hrs</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>MD for A. Fedorowicz MD</b>				29c. LICENSE NUMBER <b>D44553</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A Fedorowicz Johns Hopkins Hospital, Baltimore MD 21287</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <b>John A. Anderson</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14726

Item: 7 per Informant G-750 8/27/97 dh

1. STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Sarah HANN</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>12</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>5:20A</b> M	
4. SOCIAL SECURITY NUMBER <b>220-14-1887</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>80</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>February 26, 1915</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Howard County General Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Columbia</b>	
9c. COUNTY OF DEATH <b>Howard</b>		10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Catonsville</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>7 Wade Avenue</b>		10f. ZIP CODE <b>21228</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 6+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Nurse LPN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Health Care</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Usher Josiah Eiler</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary C. Kump</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Harry C. Hann Jr. (son)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>305 Oak Forest Ave Catonsville, Maryland 21228</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Meadowridge Cemetery May 12, 1995</b>		20c. LOCATION — City or Town, State <b>Dorsey, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>R. Chay Witzke</b>				22. NAME AND ADDRESS OF FACILITY <b>Leroy M. &amp; Russell C. Witzke Funeral Homes 1630 Edmondson Avenue Catonsville, Maryland 21228</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Metastatic Carcinoma</b>					
		DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>Non-small cell carcinoma of lung</b>					
		DUE TO (OR AS A CONSEQUENCE OF):					
		c. _____					
		DUE TO (OR AS A CONSEQUENCE OF):					
		d. _____					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
<b>Hypertension</b>							
<b>Hypothyroidism</b>							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>N/A</b> M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED <b>N/A</b>		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>N/A</b>			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>N.B. Vellanki</b>		29c. LICENSE NUMBER <b>D-30469</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 12, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>N.B. Vellanki, 9055 Chevrolet Drive #100, Elkton City, MD 21042</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>		32. REGISTRAR'S SIGNATURE <b>Julia Anderson</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14727

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ELIZABETH JACOBS</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>11</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>0305 AM</b>	
4. SOCIAL SECURITY NUMBER <b>214-22-1289</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>91</b> YRS.		7. DATE OF BIRTH MONTH <b>NOV.</b> DAY <b>8</b> YEAR <b>1903</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9. COUNTY OF DEATH <b>N/A</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>UNION MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>			
10a. STATE <b>Maryland</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>2725 Walbrook Ave.</b>				10f. ZIP CODE <b>21216</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Josuha Sisco</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Young</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Marlene Lee</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1403-D-Sage Lane Belcamp, Md. 21017</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or place of disposition) <b>MD. National</b>		20c. DATE <b>5/18/95</b>		20d. LOCATION — City or Town, State <b>Laurel, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Joseph L. Russ</b>				22. NAME AND ADDRESS OF FACILITY <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Pneumonia vs. Chronic Malignancy</b>				Approximate Interval Between Onset and Death <b>2 days</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>Suspected Malignancy, &amp;</b>				2 months	
		c. <b>GI Bleed</b>				2 months	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)	
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Andrew B. Reisman, M.D.</b>				29c. LICENSE NUMBER <b>646574</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/11/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ANDREW B. REISMAN, M.D. UNION MEMORIAL HOSPITAL</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>		REGISTRAR'S SIGNATURE <b>Johanna...</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14728

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JANE H. JONES</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 15, 1995</b>		3. TIME OF DEATH <b>6:00 A M</b>	
4. SOCIAL SECURITY NUMBER <b>358-05-6592</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 20, 1915</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>6602 Charlesway</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Towson</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6602 Charlesway</b>				10f. ZIP CODE <b>21204</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Reed H. Hubbell</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Grace Pritchard</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Sarah Jones</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6602 Charlesway, Towson, MD 21204</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Green Mount Crematory 5/16</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>ALTENBURG FUNERAL HOME, P.A. 6009 Harford Rd., Baltimore, MD 21214</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. <i>Alzheimer's Disease</i></b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>						Approximate interval Between Onset and Death <b>3 years</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D10716</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/15/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>6701 N. Charles St #5140 BALTO. MD. 21204 (410-825-5595)</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12



95 14729

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Marta Armilda Kaber</b>				2. DATE OF DEATH MONTH <b>4</b> - DAY <b>18</b> - YEAR <b>95</b>		3. TIME OF DEATH <b>13:44P</b> M	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-16-1912</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>110 W. 39th Street #1101</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>na</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>na</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>110 W. 39th Street #1101</b>				10f. ZIP CODE <b>21210</b>		10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>in state removal</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald Wade, Dir</b> <i>Joseph B. ...</i>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board</b> <b>655W. Baltimore St, Balto, MD 21201</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Atherosclerotic cardiovascular disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>							Approximate interval Between Onset and Death <b>minutes</b> <b>years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic obstructive lung disease</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dwight W. ...</b>				29c. LICENSE NUMBER <b>026394</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/11/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR ALLEN KIMMEL</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b> <b>John ...</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ALLEINE KRESS</b>				2. DATE OF DEATH MONTH <b>5</b> DAY <b>6</b> YEAR <b>95</b>		3. TIME OF DEATH <b>520 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>219-18-4301</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 23, 1925</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>BAYVIEW MEDICAL CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH				10a. STATE <b>Md.</b>			
10b. COUNTY <b>Harford</b>				10c. CITY, TOWN OR LOCATION <b>Bel Air</b>			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>761 SOUTH ATWOOD Rd</b>			
10f. ZIP CODE <b>21014</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>CHARLES L. RICHARDS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARGARET A. O'Malley</b>			
19a. INFORMANT'S NAME (Type/Print) <b>KATHLEEN WINDZIGL</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>512 SCHOOL HOUSE Rd. NAZARETH, PA 18064</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem. Gdns 5/11/95</b>		20c. LOCATION — City or Town, State <b>TIMONIUM, Md.</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert W. Jones</b>	
22. NAME AND ADDRESS OF FACILITY <b>EVANS Funeral Chapel - Bel Air 3 NEWPORT DR. Forest Hill, Md. 21050</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>LARGE CELL LYMPHOMA</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  <b>DIABETES, RENAL INSUFFICIENCY DIVERTICULOSIS, ANEMIA</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>					
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>DR. H. BERTOLZI MD MEDICAL HOUSESTAFF</b>		29c. LICENSE NUMBER <b>95003 (J Hopkins)</b>		29d. DATE SIGNED (Month, Day, Year) <b>5-6-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. H. BERTOLZI, JOHNS HOPKINS BAYVIEW MED CENTER, 4940 EASTERN AVE, BALT., MD 21224</b>		31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>					
32. REGISTRAR'S SIGNATURE <b>John D. ...</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 14731

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHRISTINE VOELKER KEYS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 14, 1995</b>		3. TIME OF DEATH <b>12:05 AM</b>	
4. SOCIAL SECURITY NUMBER <b>219-56-2825</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>44</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JULY 23, 1950</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>809 CALVIN PLACE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BELAIR</b>		9c. COUNTY OF DEATH <b>HARFORD</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>HARFORD</b>		10c. CITY, TOWN OR LOCATION <b>BELAIR</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>809 CALVIN PLACE</b>		10f. ZIP CODE <b>21014</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YRS.</b> College (1-4 or 5+) <b>5 YRS.</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>PROGRAMMER ANALYST</b>				16b. KIND OF BUSINESS/INDUSTRY <b>BALTIMORE COUNTY</b>		17. FATHER'S NAME (First, Middle, Last) <b>JOHN G. VOELKER, SR.</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>PATRICIA BOYLE</b>				19a. INFORMANT'S NAME (Type/Print) <b>MICHAEL P. KEYS</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>809 CALVIN PLACE BELAIR, MARYLAND 21014</b>	
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GREEN MOUNT CEMETERY 5-16</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Mark J. ...</b>				22. NAME AND ADDRESS OF FACILITY <b>EVANS CHAPEL OF CHIMES 2325 YORK ROAD - Timonium</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic malignant melanoma</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>primary Ocular Melanoma</b> DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>David Van Fcho</b>		29c. LICENSE NUMBER <b>D24532</b>	
29d. DATE SIGNED (Month, Day, Year) <b>MAY 15, 1995</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. DAVID VAN FCHO 22 S GREENE STREET BALTIMORE MD 21201</b>		31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>	
32. REGISTRAR'S SIGNATURE <b>John ...</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14732

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JEROME EDWARD KURNEY				2. DATE OF DEATH MAY 9, 1995		3. TIME OF DEATH 8:50 A M	
4. SOCIAL SECURITY NUMBER 217-68-1577		5. SEX X M 2 F		6. AGE (In yrs. last birthday) 52		7. DATE OF BIRTH MAR. 18, 1943	
9a. FACILITY NAME (If not Institution, give street and number) 201 BROADWAY APT. 21 E				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH n/a	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 YES 2 NO	
10e. STREET AND NUMBER 201 BROADWAY APT. 21 E				10f. ZIP CODE 21231		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TH College (1-4 or 5+) -		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER		16b. KIND OF BUSINESS/INDUSTRY VARIOUS TRADES			
17. FATHER'S NAME (First, Middle, Last) KURNEY				18. MOTHER'S NAME (First, Middle, Maiden Surname) unknown			
19a. INFORMANT'S NAME (Type/Print) KELLY KURNEY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 CALHOUN STREET, BALTIMORE, MARYLAND 21223			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) MT. ZION CEMETERY		DATE 5-15		20c. LOCATION — City or Town, State LANSDOWNE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Spencer F. Jones</i>				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Refractory Hemorrhage				Approximate interval Between Onset and Death 1 hour	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. Hepatic Cirrhosis				8 years	
		c. Alcoholism					
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael Weiner MD</i> MEDICAL		29c. LICENSE NUMBER RESIDENT		29d. DATE SIGNED (Month, Day, Year) MAY 15, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL WEINER, JOHNS HOPKINS HOSP., 600 N. WOLFE ST., BALTO, MD 21287							
31. DATE FILED (Month, Day, Year) MAY 15 1995		32. REGISTRAR'S SIGNATURE <i>John H. Russell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


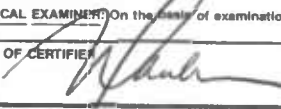
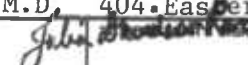
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14733

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elizabeth <b>SADIE</b> LAUDENKLOS				2. DATE OF DEATH MONTH DAY YEAR May 8, 1995		3. TIME OF DEATH 1:30 p <sup>m</sup>	
4. SOCIAL SECURITY NUMBER 215-40-1057		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 30, 1908	
9a. FACILITY NAME (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH ROSSVILLE		9c. COUNTY OF DEATH Baltimore County	
10a. STATE MD				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Perry Hall	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 3709 OAKFALLS WAY				10f. ZIP CODE 21236		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 8 College (1-4 or 5+) —		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FARMER		16b. KIND OF BUSINESS/INDUSTRY Self Employed			
17. FATHER'S NAME (First, Middle, Last) LEONARD LAUDENKLOS				18. MOTHER'S NAME (First, Middle, Maiden Surname) KATHERINE M. Schuessler			
19a. INFORMANT'S NAME (Type/Print) LEONARD C. LAUDENKLOS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3709 OAKFALLS WAY Perry Hall, Md. 21236			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) PARKWOOD CEMETERY 5/11/95		20c. LOCATION — City or Town, State Parkville, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIES 8800 Harford Rd. Balto. Md. 21234			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Massive intracranial hemorrhage</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ c. _____ d. _____							Approximate interval Between Onset and Death 1 week
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>History of Alzheimers Disease</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				29. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 18326		29d. DATE SIGNED (Month, Day, Year) 5/8/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Naeem Gauhar, M.D., 404 East Perry Boulevard, Baltimore, MD 21221							
31. DATE FILED (Month, Day, Year) MAY 15 1995 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14734

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Elizabeth Lane</i>				2. DATE OF DEATH MONTH <i>5</i> DAY <i>10</i> YEAR <i>95</i>		3. TIME OF DEATH <i>1:50P</i> M	
4. SOCIAL SECURITY NUMBER <i>212-20-2703</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>87</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>1-30-08</i>	
8. BIRTHPLACE (State or Foreign Country) <i>North Carolina</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Catonsville-Convent Center</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Balto. Md. 21228</i>	
9c. COUNTY OF DEATH <i>Balto.</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>N/A</i>	
10c. CITY, TOWN OR LOCATION <i>Baltimore</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>407 Gaither Ave.</i>	
10f. ZIP CODE <i>21228</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>0</i>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Seamstress</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Self-employed</i>			
17. FATHER'S NAME (First, Middle, Last) <i>William Henderson</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Martha Jones</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Martha Cook</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>407 Gaither Ave. Catonsville, Md. 21228</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) <i>Arbutus 5/14/95 Balto, Co. Md.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph L. Russ</i>				22. NAME AND ADDRESS OF FACILITY <i>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>DEHYDRATION</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>DEMENTIA</i> DUE TO (OR AS A CONSEQUENCE OF): Approximate interval between Onset and Death <i>2 DAYS</i> <i>10 YEARS</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <i>5/14/95</i>			
28b. TIME OF INJURY <i>M</i>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Christine L. Comerford MD</i>				29c. LICENSE NUMBER <i>D25844</i>			
29d. DATE SIGNED (Month, Day, Year) <i>5-12-95</i>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>CHRISTINE L. COMERFORD MD 5411 OLD FREDERICK RD #18 BALTIMORE MD 21229</i>			
31. DATE FILED (Month, Day, Year) <i>MAY 15 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Anderson-Rodell</i>			

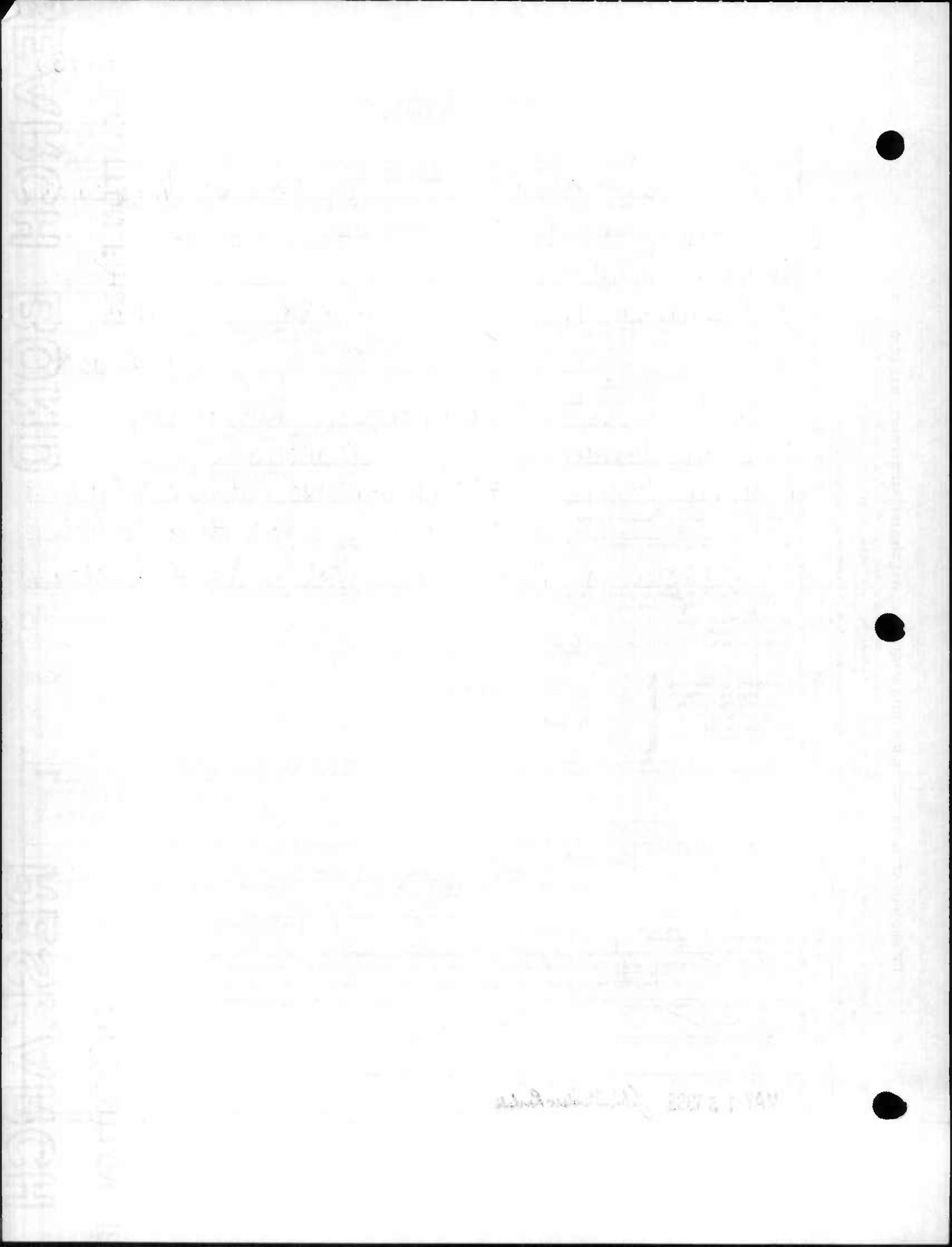
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14735

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Armeta Leake</i>				2. DATE OF DEATH MONTH DAY YEAR <i>MAY 13 95</i>		3. TIME OF DEATH <i>7:00 AM</i>	
4. SOCIAL SECURITY NUMBER <i>215-22-9080</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>74</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>JUN. 21, 1920</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Union Memorial Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>		9c. COUNTY OF DEATH <i>n/a</i>	
10a. STATE <i>MARYLAND</i>				10b. COUNTY <i>n/a</i>		10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>2561 ROBB STREET</i>			
10f. ZIP CODE <i>21218</i>				10g. CITIZEN OF WHAT COUNTRY? <i>UNITED STATES</i>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (1-12) <i>10 TH</i> College (1-4 or 5+) <i>-</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>GARMET WORKER</i>		16b. KIND OF BUSINESS/INDUSTRY <i>CLOTHING FACTORY</i>			
17. FATHER'S NAME (First, Middle, Last) <i>PERCY BOWSER</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>ROSALEE CORNISH</i>			
19a. INFORMANT'S NAME (Type/Print) <i>BERNITA RISHER</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1701 E. 29 TH STREET, BALTIMORE, MD 21218</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>KING MEMORIAL PARK 5-17 RANDALLSTOWN, MD</i>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Alphonse E. Finney</i>				22. NAME AND ADDRESS OF FACILITY <i>WM. C. MARCH FH. - 1101 E. NORTN AVENUE</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Non alcoholic steato hepatitis.</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>GI bleeding.</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>coagulopathy</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>acute regurgitation</i>						Approximate Interval Between Onset and Death <i>1 month</i> <i>1 month</i> <i>1 month</i> <i>1 month</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>pat myositis.</i>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>SALIM HAMADE MD</i>				29c. LICENSE NUMBER <i>AT2438946F7</i>		29d. DATE SIGNED (Month, Day, Year) <i>May 13 95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Union Memorial Hospital 201 E University Parkway Baltimore MD 21218</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 15 1995</i>				32. REGISTRAR'S SIGNATURE <i>Jane Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14736

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FLORENCE MC POINTS</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>11</b> YEAR <b>95</b>		3. TIME OF DEATH <b>2:45 A M</b>	
4. SOCIAL SECURITY NUMBER <b>215-34-7171</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 4, 1917</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>St. Agnes Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>n/a</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>n/a</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1104 Wildwood Parkway</b>	
10f. ZIP CODE <b>21229</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>College 5+</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Teacher</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Balto. City Public Schools</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Major Jones</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lucy Miller</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Robert McGoings</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1104 Wildwood Parkway Baltimore, Maryland 21229</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park May 17</b>		20c. LOCATION — City or Town, State <b>Baltimore County, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Kevin Parker</b>				22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Jeffrey F. Cole, M.D.</b>				29c. LICENSE NUMBER <b>P21512</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/12/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Jeffrey F. Cole, MD 3449 Wilkens Avenue Balt, Md 21229</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <b>J. H. [Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95.14737

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES MITCHELL</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>9</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>6p.</b>	
4. SOCIAL SECURITY NUMBER <b>216-34-4209</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>57</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 1, 1938</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. CITY, TOWN OR LOCATION OF DEATH <b>Forest Heights, MD.</b>		9c. COUNTY OF DEATH <b>Prince George's</b>	
9b. FACILITY NAME (If not institution, give street and number) <b>5600 Ottawa St.</b>				RESIDENCE OF DECEDENT			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Forest Heights</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5600 Ottawa St. Forest Heights, MD.</b>				10f. ZIP CODE <b>20745</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12th Grade</b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Chief of Operations</b>		16b. KIND OF BUSINESS/INDUSTRY <b>United States Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Joseph Mitchell</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sarah Wormley</b>			
19a. INFORMANT'S NAME (Type/Print) <b>William Armstrong</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5600 Ottawa St. Forest Heights, MD. 20745</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest Vet. Cem. 5/15</b>		20c. LOCATION — City or Town, State <b>Owings Mills, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Herbert E. Nutter</b>				22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Balto., MD. 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Diabetic arteriosclerotic cardiovascular disease</b> a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Augusto P. Rodriguez MD</b>				29c. LICENSE NUMBER <b>D21230</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 9, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Augusto P. Rodriguez, M.D. 5009 Rayburn Ct., Camp Springs, MD 20748</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <b>J. H. Hudson</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14738

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Lena Adele Marcuson</u>				2. DATE OF DEATH MONTH <u>MAY</u> DAY <u>2</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>2:53 A.M.</u> M	
4. SOCIAL SECURITY NUMBER <u>012-25-4941</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <u>80</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>OCT-4 1914</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>FALLSTON GENERAL HOSPITAL</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>FALLSTON</u>		9c. COUNTY OF DEATH <u>HARFORD</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>MARYLAND</u>		10b. COUNTY <u>HARFORD</u>		10c. CITY, TOWN OR LOCATION <u>WHITE HALL</u>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <u>3009 BRADENBAUGH ROAD</u>				10f. ZIP CODE <u>21161</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>WHITE</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <u>8YRS.</u>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>AT HOME</u>		16b. KIND OF BUSINESS/INDUSTRY <u>HOUSEWIFE</u>			
17. FATHER'S NAME (First, Middle, Last) <u>JOSEPH TORRE</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>ANGELINA VOLATIL</u>			
19a. INFORMANT'S NAME (Type/Print) <u>MICHAEL A. JAY</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3009 BRADENBAUGH ROAD WHITE HALL, MARYLAND 21161</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>MAKOWSKI MEM. PARK 5/2</u>		20c. LOCATION — City or Town, State <u>ELKTON, MARYLAND</u>		22. NAME AND ADDRESS OF FACILITY <u>EVANS FUNERAL CHAPL - BELAIR, P.A. 2100 3 NEWPORT DRIVE FOREST HILL, MARYLAND</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <u>myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Diabetes; Hypertension; old MI</u> <u>⑤ Hemiplegia</u>							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>D.H. Sherbourne MD</u>				29c. LICENSE NUMBER <u>D13401</u>		29d. DATE SIGNED (Month, Day, Year) <u>MAY 2, 1995</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>DR DONALD H. SHERBOURNE 9101 FRANKLIN SQUARE DRIVE</u>							
31. DATE FILED (Month, Day, Year) <u>MAY 15 1995</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Andrew Montague</i>				2. DATE OF DEATH MONTH <i>5</i> DAY <i>3</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>3:15 A.M.</i>	
4. SOCIAL SECURITY NUMBER <i>224-05-3642</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>84</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>01-08-11</i>	
8. FACILITY NAME (If not institution, give street and number) <i>Inds of Evergreen, NW</i>				9. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		10. COUNTY OF DEATH <i>NA</i>	
10a. STATE <i>MD</i>		10b. COUNTY <i>NA</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>2525 W. Belvedere Ave</i>				10f. ZIP CODE <i>21215</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8th grade</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>CAR Painter</i>		15b. KIND OF BUSINESS/INDUSTRY <i>Paint Remover Co.</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Moses Montague</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Ella A. Almond</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Margaret Montague</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2847 Edgemoor Circle Baltimore 21215</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>King Men Park 5/6/95</i>		20c. DATE <i>5/6/95</i>		20d. LOCATION — City or Town, State <i>Randallstown, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sala March</i>				22. NAME AND ADDRESS OF FACILITY <i>March F. H. West 4300 Wabash Ave Baltimore 21215</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Metastatic Adeno Ca</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <i>2 months</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Ascend Bowel obstruction</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Meach MD</i>				29c. LICENSE NUMBER <i>B69517</i>		29d. DATE SIGNED (Month, Day, Year) <i>5/4/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Allen Nettleson 1777 Raintown Rd #365</i>							
31. DATE SIGNED (Month, Day, Year) <i>MAY 15 1995</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

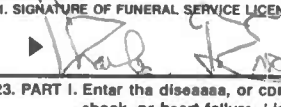
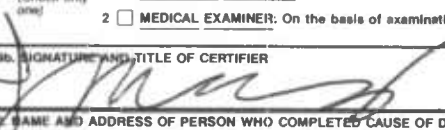



95 14740

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) <b>BETHEL L. MILBY</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>7</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>10:50 A M</b>	
4. SOCIAL SECURITY NUMBER <b>213-74-4323</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>95</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MARCH 28 1900</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		8. BIRTHPLACE (State or Foreign Country) <b>VIRGINIA</b>	
9c. COUNTY OF DEATH							
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3017 CHRISTOPHER AVE</b>				10f. ZIP CODE <b>21214</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YRS.</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>AT HOME</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOUSEWIFE</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOHN J. CREME</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EMMA GLEN BLY</b>					
19a. INFORMANT'S NAME (Type/Print) <b>PAUL F. JONES</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9309 FULEROAK AVE. CARNY, MARYLAND 21034</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BOURBON PARK CEMETERY 5-10</b>		DATE <b>BALTIMORE, MARYLAND</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>EVANS CHAPEL OF MEMORIES 3300 HARFORD ROAD - PARKVILLE</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>SEVERE HYPOXIA</b> DUE TO (OR AS A CONSEQUENCE OF):  b. <b>ASPIRATION PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>30 Min.</b> <b>2 days</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Heart Failure</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>M.D.</b>		29c. LICENSE NUMBER <b>P07708</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 7, 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GOOD SAMARITAN HOSP, 5201 LOCH RAVEN BLVD, BALTO, MD 21239</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



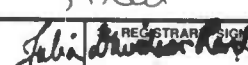
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14741

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Catherine C. Myers</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>12</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>12:20 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>215-09-1240</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 15, 1912</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Cherrywood Manor Nursing &amp; Conv. Ctr.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Reisterstown</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Owings Mills</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>15 Timbergrove Rd.</b>				10f. ZIP CODE <b>21117</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Saleslady</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Dept. Store</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Joseph Chaney</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Catherine V. Cruthers</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Robert D. Myers</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15 Timbergrove Rd., Owings Mills, Md. 21117</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Evergreen Mem. Gardens May, 15, 1995 Finksburg, Md.</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Eckhardt Funeral Chapel 21117 11605 Reisterstown Rd., Owings Mills, Md.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Septic</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <b>4 yrs</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Longtime heart failure Hypertension</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>D27123</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/12/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>750 Main Street Reisterstown, MD 21116</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>		REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14742

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ESMILDA MILLER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 13 1995</b>		3. TIME OF DEATH <b>6:05 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>133-34-7665</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 30, 1915</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Lorien Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Columbia</b>		9c. COUNTY OF DEATH <b>Howard</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Howard</b>		10c. CITY, TOWN OR LOCATION <b>Columbia</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6334 Cedar Lane</b>				10f. ZIP CODE <b>21044</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Home Maker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Alexander McAllister</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Emma Bahiem</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Carol Bowen (Daughter)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5524 Vantage Point Road Columbia, Maryland 21044</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Crestlawn Cemetery May 17, 1995</b>		DATE <b>May 17, 1995</b>		20c. LOCATION — City or Town, State <b>Marriottsville, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Leroy M &amp; Russell C Witzke Funeral Homes 1630 Edmondson Avenue Catonsville, Maryland</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>metastatic breast cancer</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>&gt; 1yr</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>122621</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/13/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GARY MILLS 3460 Ellicott Center Drive, Ellicott City, Md.</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14743

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Carlton E. Ohlheiser				2. DATE OF DEATH MONTH DAY YEAR May 8 1995		3. TIME OF DEATH 1:15 P M	
4. SOCIAL SECURITY NUMBER 252-01-3127		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 87 YRS.	7. DATE OF BIRTH (Month, Day, Year) May 16, 1907		8. BIRTHPLACE (State or Foreign Country) N.Y.	
9a. FACILITY NAME (If not institution, give street and number) 5764 Stevens Forest Road, Apt. 518				9b. CITY, TOWN OR LOCATION OF DEATH Columbia		9c. COUNTY OF DEATH Howard	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Columbia		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5764 Stevens Forest Road				10f. ZIP CODE 21045		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer/President		16b. KIND OF BUSINESS/INDUSTRY Hygro Dynamics Inc.			
17. FATHER'S NAME (First, Middle, Last) George Ohlheiser				18. MOTHER'S NAME (First, Middle, Maiden Surname) Flora Russell			
19a. INFORMANT'S NAME (Type/Print) Blanche Ohlheiser (Spouse)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5764 Stevens Forest Rd. Columbia, MD 21045			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory May 12, 1995		20c. LOCATION — City or Town, State Catonsville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. C. Witzke Jr.</i>				22. NAME AND ADDRESS OF FACILITY Leroy & Russell Witzke Funeral Home 5555 Twin Knolls Rd. Columbia, MD 21045			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Small Cell Carcinoma of the Prostate gland. DUE TO (OR AS A CONSEQUENCE OF): Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 3 months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. N/A							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. K. J. W. D.</i>				29c. LICENSE NUMBER 241139		29d. DATE SIGNED (Month, Day, Year) 5/9/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 11065 Little Potomac Parkway, Columbia, M.D.							
31. DATE FILED (Month, Day, Year) MAY 15 1995				32. REGISTRAR'S SIGNATURE <i>John A. Russell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14744

FilmG, 723, item #1, 5/15/95, cyw, per f.h.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WALTER JOHN PLICHTA</b>				2. DATE OF DEATH MONTH <b>5</b> DAY <b>9</b> YEAR <b>95</b>		3. TIME OF DEATH <b>1055A</b>	
4. SOCIAL SECURITY NUMBER <b>213-07-8651</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 8, 1912</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>7414 Alvah Ave. Apt. F</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Dundalk</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Dundalk</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7414 Alvah Avenue Apt. F</b>				10f. ZIP CODE <b>21222</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9 Years</b> College (14 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Labor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Steel Industry</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Frank J. Plichta</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary A. Wisniewski</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Lillian S. Plichta</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7414 Alvah Avenue Apt. F Dundalk, MD 21222</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parkwood Cemetery May 12, 1995</b>		20c. LOCATION — City or Town, State <b>Parkville, Maryland</b>		20d. DATE <b>May 12, 1995</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Johnny L. Gibb</b>				22. NAME AND ADDRESS OF FACILITY <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>GASTROINTESTINAL HEMORRHAGE</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>RENAL FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>COLON CANCER</b> DUE TO (OR AS A CONSEQUENCE OF): c. d. Approximate interval between Onset and Death <b>5/9/95</b> <b>7/94</b> <b>6/92</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b> <b>MULTIPLE CVA</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Michael A. Ankrom MD</b>				29c. LICENSE NUMBER <b>D46360</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/9/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MICHAEL A. ANKROM MD 5505 HOPKINS BAYVIEW CIRCLE BALTIMORE MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <b>in Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14745

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>James B. Pierce</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>12</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>12:50 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>218-18-4153</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 5, 1925</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Md</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Liberty Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>NA</b>				10a. STATE <b>Md</b>		10b. COUNTY <b>NA</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>624 Mt Holly Street</b>	
10f. ZIP CODE <b>21229</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th grade</b> College (1-4 or 5+) <b>NA</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>laborer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Liquor - Wine</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Paul Pierce</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Inez L. Waddy</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Geraldine Pore</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>624 Mt Holly Street Balto, Md 21229</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest Vet 5/17/95</b>		20c. LOCATION — City or Town, State <b>Quings Mills, Md</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Bladine Wanner</b>				22. NAME AND ADDRESS OF FACILITY <b>March F. H. West 4300 Wabash Ave Balto, Md 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Acute Renal Failure</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Gangrenous Right Foot</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Renal Failure</b> <b>Diabetes Mellitus</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>George E. Wickes III M.D.</b>				29c. LICENSE NUMBER <b>D41365</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 12, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>George E. Wickes III M.D. 2600 Liberty Heights Ave 21216</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <b>John A. Hudson</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


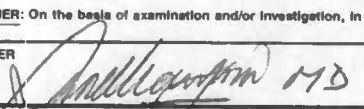
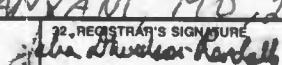
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>OKLAHOMA PUGH</u> <u>Oklaoma Pugh</u>		2. DATE OF DEATH MONTH DAY YEAR <u>May 08 1995</u>		3. TIME OF DEATH <u>2:15PM</u> M	
4. SOCIAL SECURITY NUMBER <u>212-50-5331</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>85</u> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <u>June 14, 1909</u>		8. BIRTHPLACE (State or Foreign Country) <u>North Carolina</u>			
9a. FACILITY NAME (If not institution, give street and number) <u>CALVERT MANOR Nursing Home</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>RISING SUN</u>		9c. COUNTY OF DEATH <u>Cecil</u>	
10a. STATE <u>Md</u>		10b. COUNTY <u>Harford</u>		10c. CITY, TOWN OR LOCATION <u>Forest Hill</u>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <u>2403 Bailey Rd.</u>		10f. ZIP CODE <u>21050</u>	
10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>WHITE</u>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>—</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>HOUSEWIFE</u>		16b. KIND OF BUSINESS/INDUSTRY <u>HOME</u>	
17. FATHER'S NAME (First, Middle, Last) <u>William Sturgill</u>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Emma Weiss</u>			
19a. INFORMANT'S NAME (Type/Print) <u>GUY E. PUGH</u>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2403 BAILEY Rd. Forest Hill, Md. 21050</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Bel Air Memorial Gardens</u> DATE <u>5/12/95</u>		20c. LOCATION — City or Town, State <u>Bel Air Md</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <u>EVANS FUNERAL Chapel - Bel Air</u> <u>3 NEWPORT DR. Forest Hill, Md. 21050</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>CORONARY ARTERY DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>—</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>—</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>DIABETES MELLITUS, DEMENTIA, PSORIASIS</u>					24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER  MD		29c. LICENSE NUMBER <u>D45344</u>		29d. DATE SIGNED (Month, Day, Year) <u>5/9/95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>SURESH DHANTANI MD, 20 CRAIGTOWN RD, PERRYVILLE, MD 21903</u>					
31. DATE FILED (Month, Day, Year) <u>MAY 15 1995</u>		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

May 12 1932

May 12 1932

May 12 1932

95 14747

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Charles Howard Polley</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>13</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>8:15 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>212-01-4879</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>82</b> YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	7. DATE OF BIRTH (Month, Day, Year) <b>May 02, 1913</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>THE UNION MEMORIAL HOSP.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>5503 Knell Ave.</b>				10f. ZIP CODE <b>21206</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W.W.II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Grocer</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Grocery Store</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Thomas E. Polley</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Agnes Schultz</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Bernard H. Polley</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5851 Arizona Ave. Baltimore, Md. 21206</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gardens of Faith Cemetery</b>		DATE <b>5/17/95</b>		20c. LOCATION — City or Town, State <b>Rossville, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Jeffrey L. Gair</b>				22. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Respiratory failure</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>aspiration pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b></b> DUE TO (OR AS A CONSEQUENCE OF): d. <b></b> Approximate interval between Onset and Death <b>1 day</b> <b>5 days</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHF, Alzheimers, HTN</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Patricia Ayres</b>				29c. LICENSE NUMBER <b>P08074</b>		29d. DATE SIGNED (Month, Day, Year) <b>05/13/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>2016 UNIVERSITY PARKWAY, BALTIMORE, MD PATRICIA AYRES</b>							
31. DATE FILED (Month, Day, Year) <b>05/13/95</b>				32. REGISTRAR'S SIGNATURE <b>John Andrew Kestell</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

8

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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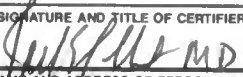
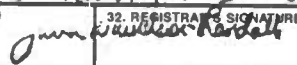
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ALBANY, N. Y. 1892

95-14748

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Stephen Bartolo Prestianni				2. DATE OF DEATH MONTH DAY YEAR May 7, 1995		3. TIME OF DEATH 4:50 AM M	
4. SOCIAL SECURITY NUMBER 213-72-1961		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 35 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug 6, 1959	
9a. FACILITY NAME (If not institution, give street and number) 10109 Lyons Mill Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Owings Mills		9c. COUNTY OF DEATH Baltimore County	
10a. STATE Maryland				10b. COUNTY Baltimore Co.		10c. CITY, TOWN OR LOCATION Owings Mills	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 10109 Lyons Mills Rd.			
10f. ZIP CODE 21117				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 years				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Dance Instructor		16b. KIND OF BUSINESS/INDUSTRY Dance Studio	
17. FATHER'S NAME (First, Middle, Last) Joseph G. Prestianni, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna M. Sullivan			
19a. INFORMANT'S NAME (Type/Print) Mr. John Prestianni				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 52 Chins Ct. Owings Mills, MD 21117			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Park 5-10		20c. LOCATION — City or Town, State Elkridge, MD		20d. DATE 5-10	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Disseminated Mycobacterium avium complex b. Retroviral Infection. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. d. Approximate Interval Between Onset and Death 15 mos 10 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CMV Retinitis CMV Duodenitis DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD				29c. LICENSE NUMBER D38398		29d. DATE SIGNED (Month, Day, Year) 5-9-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joel E. Gallant, MD 600 N. Wolfe St, Carnegie 292, Baltimore, MD 21287							
31. DATE FILED (Month, Day, Year) MAY 15 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Item 9a, Film 723, 5/23/95, 1t

Film G, 723, item #19a, 5/26/95, cyw, per f.h.

95 14749

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ida Elizabeth Palmer				2. DATE OF DEATH MONTH DAY YEAR May 10, 1995		3. TIME OF DEATH 8:00 P M	
4. SOCIAL SECURITY NUMBER 219-28-4402		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 99 YRS.	7. DATE OF BIRTH (Month, Day, Year) August 16, 1895	8. BIRTHPLACE (State or Foreign Country) Maryland		
9a. FACILITY NAME (If not institution, give street and number) Golden Age Guest Home				9b. CITY, TOWN OR LOCATION OF DEATH Eldersburg		9c. COUNTY OF DEATH Carroll	
10a. STATE Maryland		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Eldersburg		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6625 Carroll Highlands Road				10f. ZIP CODE 21784		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 Years College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales Person		16b. KIND OF BUSINESS/INDUSTRY Hecht Department Store			
17. FATHER'S NAME (First, Middle, Last) John S. Walters				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mollie Seward			
19a. INFORMANT'S NAME Mr. William M. Palmer Mr. Merrill Palmer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6625 Carroll Highlands Road Eldersburg, MD 21784			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Stevensville Cemetery 5/16/95		20c. LOCATION — City or Town, State Stevensville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen M. Jenkins</i>				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Alzheimer's disease</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Coronary artery disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Patrick Turner</i>		29c. LICENSE NUMBER D20806	
29d. DATE SIGNED (Month, Day, Year) 5/12/95				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PATRICK TURNER, MD 1425 LIBERTY RD ELDERSBURG MD			
31. DATE FILED (Month, Day, Year) MAY 15 1995				32. REGISTRAR'S SIGNATURE <i>Julia...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14750

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOSEPH RUSSIN</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>9</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>4:45 A M</b>	
4. SOCIAL SECURITY NUMBER <b>187-16-3804</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>December 27, 1922</b>		8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>				9c. COUNTY OF DEATH	
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>16 Compass Road</b>				10f. ZIP CODE <b>21220</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>welder</b>				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Charles Russin</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Sewo</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Elsie Russin</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16 Compass Rd., Balto., MD 21220</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade</i> <b>Ronald Wade, Dir.</b>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board</b> <b>655 West Baltimore St., Balto., MD 21201</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cancer cachexia</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>bony metastases</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>prostate cancer</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>prostate cancer</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate interval Between Onset and Death <b>2 mths</b> <b>2 yrs</b> <b>4 yrs</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Rainer K. Brachmann</i>		29c. LICENSE NUMBER <b>L 0372</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/9/95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Rainer K. Brachmann 600 W Wolfe St. Baltimore</b>									
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>		32. REGISTRAR'S SIGNATURE <i>John Brachmann</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14751

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Beatrice Ratcliffe</u>				2. DATE OF DEATH MONTH <u>5</u> DAY <u>10</u> YEAR <u>95</u>		3. TIME OF DEATH <u>8:52 p</u> M	
4. SOCIAL SECURITY NUMBER <u>319 10 6878</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>92</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>8-17-03</u>	
8. BIRTHPLACE (State or Foreign Country) <u>MARYLAND</u>		9a. FACILITY NAME (If not institution, give street and number) <u>Bel Forest Nsg + Rehab Ctr</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Forest Hill</u>		9c. COUNTY OF DEATH <u>HARFORD</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>MD</u>		10b. COUNTY <u>HARFORD</u>		10c. CITY, TOWN OR LOCATION <u>Forest Hill</u>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>109 Forest Valley Dr</u>				10f. ZIP CODE <u>21050</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>WHITE</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12 YRS.</u> College (1-4 or 5+) <u>AT HOME</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>HOUSEWIFE</u>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <u>ROBERT CRAIG MIANAHAN</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>ADDIE E. FORD</u>			
19a. INFORMANT'S NAME (Type/Print) <u>BETTY R. WILLIS</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>21014 102 COUNTRY VILLAGE DRIVE BELAIR, MARYLAND</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>LAUREL PARK CEMETERY</u>		DATE <u>5-12-95</u>		20c. LOCATION — City or Town, State <u>BALTIMORE, MARYLAND</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY <u>EVANS FUNERAL CHAPEL - BALAIR, P.A. 21020 3 NEWPORT DRIVE FOREST HILL, MARYLAND</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Natural causes (Age 92)</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>atrial fibrillation</u> <u>He of hip fracture</u> <u>Hypothyroidism</u> <u>Dementia</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u>				29c. LICENSE NUMBER <u>027975</u>		29d. DATE SIGNED (Month, Day, Year) <u>5/12/95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>DAVID McCLURE JR 1131 Bel Air Road Bel Air Md 21014</u>							
31. DATE FILED (Month, Day, Year) <u>MAY 15 1995</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STANDARD LIBRARY

STANDARD LIBRARY

STANDARD LIBRARY

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BETTY LOUISE RIDGELY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 26 1995</b>		3. TIME OF DEATH <b>1:20 P M</b>	
4. SOCIAL SECURITY NUMBER <b>217-20-8266</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68 68YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>AUG 2, 1926</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>STELLA MARIS HOSPICE</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>Md.</b>		10b. COUNTY <b>BALTIMORE</b>	
10c. CITY, TOWN OR LOCATION <b>COCKEYSVILLE</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>10127 DAVENTRY DR</b>	
10f. ZIP CODE <b>21030</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>6</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DIRECTOR OF ADMINISTRATION</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Research + Development</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Melvin R. Hoshall</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELIZABETH LEIZEAR</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CAROL Kessler</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3404 ACTON Rd. BALTIMORE Md 21234</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem Gdns 4/29/95</b>		20c. LOCATION — City or Town, State <b>TIMONIUM, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>EVANS CHAPEL OF CHIMES 2325 YORK Rd. TIMONIUM, Md. 21093</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lung Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death <b>8 months</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Breast Cancer</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kendall E Faulkner</i>				29c. LICENSE NUMBER <b>D25643</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/26/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. KENDALL FAULKNER 2300 DULANEY VALLEY ROAD TOWSON, MD 21204</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 14753

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EDITH REICHERT</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 10, 1995</b>		3. TIME OF DEATH <b>11:15 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>215-34-0924</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>80</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>June 21, 1914</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>STELLA MARIS</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Md</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Cockeysville</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>611-C Cranbrook Rd</b>		10f. ZIP CODE <b>21030</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>12</b> College (1-4 or 5+) <b>-</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CLERK TYPIST</b>				16b. KIND OF BUSINESS/INDUSTRY <b>INSURANCE</b>		17. FATHER'S NAME (First, Middle, Last) <b>FRED Hofsass</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MAY DAVIS</b>				19a. INFORMANT'S NAME (Type/Print) <b>Frederick REICHERT</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>611-C Cranbrook Rd Cockeysville, Md 21030</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>LOUDON PARK Cemetery 5/13/95</b>		20c. LOCATION — City or Town, State <b>Balto. Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>EVANS CHAPEL of Chimies 2325 York Rd Timonium Md 21093</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Leering Cancer</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>Kendall R Faulkner</b>		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Kendall R Faulkner</b>	
29c. LICENSE NUMBER <b>D2543</b>				29d. DATE SIGNED (Month, Day, Year) <b>5/10/95</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204</b>	
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MICHAEL REED</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 11 1995</b>		3. TIME OF DEATH <b>2:15 A M</b>	
4. SOCIAL SECURITY NUMBER <b>072-60-2557</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>22</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jun. 14, 1972</b>	
8. BIRTHPLACE (State or Foreign Country) <b>New York</b>				9a. FACILITY NAME (If not institution, give street and number) <b>4300 BLK ADELLE TERRACE</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>New York</b>			
10b. COUNTY <b>N/A</b>				10c. CITY, TOWN OR LOCATION <b>Far Rockway</b>			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>20-43 Seagrit Boulevard</b>			
10f. ZIP CODE <b>11691</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Maintenance</b>		16b. KIND OF BUSINESS/INDUSTRY <b>various</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Michael Reed, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Julia Montgomery</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Michael Reed, Sr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2-43 Seagrit Boulevard/Far Rockway, N.Y. 11691</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Sinai Cemetery</b>		20c. LOCATION — City or Town, State <b>5-13 Lamar, South Carolina</b>		20d. DATE <b>5-13</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wynne B. Scott</i>				22. NAME AND ADDRESS OF FACILITY <b>March Funeral Home East 1101 E. North Avenue/Baltimore, MD 21202</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Gunshot Wounds of the Head</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>5-11-95</b>		28b. TIME OF INJURY <b>0039A M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED <b>subject shot</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>street</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>4300 Blk Adelle Terrace Baltimore, Md</b>			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chute md</i>		29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 11, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>		32. REGISTRAR'S SIGNATURE <i>John Andrew Radell</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



95 14755

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Svea A. Russell				2. DATE OF DEATH MONTH DAY YEAR May 12 1995		3. TIME OF DEATH 3:40 A M	
4. SOCIAL SECURITY NUMBER 089-10-6413		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar. 31, 1909	
8. BIRTHPLACE (State or Foreign Country) Michigan				9a. FACILITY NAME (If not institution, give street and number) Vantage House		9b. CITY, TOWN OR LOCATION OF DEATH Columbia	
9c. COUNTY OF DEATH Howard				10a. STATE MD		10b. COUNTY Howard	
10c. CITY, TOWN OR LOCATION Columbia				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 5400 Vantage Point Road	
10f. ZIP CODE 21044				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Alfred Anderson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Louisa Stenros			
19a. INFORMANT'S NAME (Type/Print) Joy A. Rose (Daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11120 Wood Elves Way, Columbia, MD 21044			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory May 13, 1995 Catonsville, MD		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>L. Russell Witzke</i>				22. NAME AND ADDRESS OF FACILITY Leroy & Russell Witzke Funeral Home 5555 Twin Knolls Rd. Columbia, MD 21045			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ischemic Heart Disease DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 1 year.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER William Flowers MD		29c. LICENSE NUMBER D20798		29d. DATE SIGNED (Month, Day, Year) May 12, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William Flowers MD 11055 Little Patuxent Columbia MD							
31. DATE FILED (Month, Day, Year) MAY 15 1995		32. REGISTRAR'S SIGNATURE <i>John [Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14756

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Rosalind Mildred Robertson</b>				2. DATE OF DEATH MONTH <b>5</b> DAY <b>7</b> YEAR <b>95</b>		3. TIME OF DEATH <b>8:48 PM</b>	
4. SOCIAL SECURITY NUMBER <b>212-09-2220</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-17-1913</b>	
8. BIRTHPLACE (State or Foreign Country) <b>PA.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Bel-Forest Nsg Ctr</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>FOREST HILL, MD</b>	
9c. COUNTY OF DEATH <b>HARFORD</b>				10a. STATE <b>MARYLAND</b>			
10b. COUNTY <b>HARFORD</b>				10c. CITY, TOWN OR LOCATION <b>Bel Air</b>			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>722 BEDFORD ROAD</b>			
10f. ZIP CODE <b>21014</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YRS</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>AT Home</b>		15b. KIND OF BUSINESS/INDUSTRY <b>HOUSEWIFE</b>			
16. DECEDENT'S EDUCATION (Specify only highest grade completed) College (14 or 5+) <b>2 YRS</b>				17. FATHER'S NAME (First, Middle, Last) <b>William Roebig</b>			
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth Hoffman</b>				19a. INFORMANT'S NAME (Type/Print) <b>JAMES L ROBERTSON, JR.</b>			
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>722 BEDFORD ROAD BEL AIR, MARYLAND 21014</b>				20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>LAUREL PARK CEMETERY, SE 11</b>				20c. LOCATION — City or Town, State <b>BALTIMORE, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>David S. Dunn</b>				22. NAME AND ADDRESS OF FACILITY <b>SWAN FUNERAL CHAPEL - BEL AIR, P.A. 21000</b> <b>30 NEWPORT DRIVE FOREST HILL, MARYLAND</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Parkinson's disease</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>David S. Dunn</b>				29c. LICENSE NUMBER <b>D32297</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 8, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DAVID S. DUNN 2405 LAUREL BUSH RD</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <b>John H. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNITED STATES OF AMERICA

DEPARTMENT OF THE INTERIOR

WASHINGTON, D. C.

OFFICE OF THE SECRETARY OF THE INTERIOR

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ANNA SOKAL</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>9th</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>9:20 a M</b>	
4. SOCIAL SECURITY NUMBER <b>219-38-9320</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>93</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>05/11/02</b>		8. BIRTHPLACE (State or Foreign Country) <b>Poland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Harbor Hospital, 3001 S. Hanover St.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH <b>Baltimore City</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2226 E. Lombard St.</b>				10f. ZIP CODE <b>21231</b>				10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <b>unknown</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>unknown</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+) <b>unknown</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>unknown</b>				16b. KIND OF BUSINESS/INDUSTRY <b>unknown</b>	
17. FATHER'S NAME (First, Middle, Last) <b>unknown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>unknown</b>					
19a. INFORMANT'S NAME (Type/Print) <b>unknown</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>unknown</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>unknown</b>				20c. LOCATION — City or Town, State <b>unknown</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade</i> <b>5/1/95</b>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board</b> <b>655 West Baltimore St., Balto., MD 21201</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) →									
a. <b>End stage Congestive Heart failure</b> Approximate Interval Between Onset and Death <b>30 days</b>									
b. <b>Chronic Atrial fibrillation</b> <b>several</b>									
c. <b>Dehydration</b> <b>10 days</b>									
d.									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
				28d. DESCRIBE NOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Thomp HOUSE STAFF</b>				29c. LICENSE NUMBER <b>A52441614</b>				29d. DATE SIGNED (Month, Day, Year) <b>May 9th 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>KRATIRNA SHARMA HARBOR HOSPITAL CENTER</b>									
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Rodell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14758

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Marie Madeline Smith				2. DATE OF DEATH MONTH DAY YEAR May 12, 1995		3. TIME OF DEATH 3:20 A M	
4. SOCIAL SECURITY NUMBER 215 80 4006		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) 02 01 09	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Rossville	
9c. COUNTY OF DEATH Baltimore				10a. STATE Md.		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 5603 Remmell Avenue	
10f. ZIP CODE 21206				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 1				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housework		16b. KIND OF BUSINESS/INDUSTRY At Home	
17. FATHER'S NAME (First, Middle, Last) Jan Zajdel				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Szczepaniak			
19a. INFORMANT'S NAME (Type/Print) Louis R. Smith Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5603 Remmell Ave. Balto., Md. 21206			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 5-15-95		20c. LOCATION — City or Town, State Eastwood, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles S. Zeiler				22. NAME AND ADDRESS OF FACILITY Charles S. Zeiler & Son Inc. 6224 Eastern Avenue Balto., Md.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular Accident, Right Temporal and Parietal b. Arteriosclerotic Cardiovascular Disease c. d. Approximate Interval Between Onset and Death 4 Days							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Sheldon Milner M.D.				29c. LICENSE NUMBER D 18598		29d. DATE SIGNED (Month, Day, Year) 5/12/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sheldon Milner M.D. 404 Eastern Blvd 21221							
31. DATE FILED (Month, Day, Year) MAY 15 1995				32. REGISTRAR'S SIGNATURE John A. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14759

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Harriet Elaine Smith</u>				2. DATE OF DEATH MONTH DAY YEAR May 12, 1995		3. TIME OF DEATH 5:55 a.m.	
4. SOCIAL SECURITY NUMBER 195 20 8590		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11 15 15	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital			
10. CITY, TOWN OR LOCATION OF DEATH Rossville				11. COUNTY OF DEATH Baltimore County			
12a. STATE Md.		12b. COUNTY Baltimore		12c. CITY, TOWN OR LOCATION Bowley's Quarters		12d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
13. STREET AND NUMBER 616 B Carrollwood Road				14. ZIP CODE 21220		15. CITIZEN OF WHAT COUNTRY? USA	
16. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		17. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		19. RACE — American Indian, Black, White, etc. Specify: White	
20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 7		21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housework		22. KIND OF BUSINESS/INDUSTRY At Home			
23. FATHER'S NAME (First, Middle, Last) Thoms Russell Williams				24. MOTHER'S NAME (First, Middle, Maiden Surname) Harriet Esther Knight			
25. INFORMANT'S NAME (Type/Print) Charles E. Smith III				26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1111 A Queen's Purchase Rd. Balto., Md. 21221			
27. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		28. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 5-15-95		29. LOCATION — City or Town, State Eastwood, Md.			
30. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Charles S. Zeiler</u>				31. NAME AND ADDRESS OF FACILITY Charles S. Zeiler & Son Inc. 6224 Eastern Ave. Balto., Md.			
32. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Diabetes Mellitus</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Chronic Obstructive Pulmonary Disease</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>Congestive Heart Failure</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
33. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Peripheral Vascular Disease</u>							
34. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		35. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
36. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
37. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		38. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
39. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Could not be determined		40. DATE OF INJURY (Month, Day, Year)		41. TIME OF INJURY M		42. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
43. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				44. DESCRIBE HOW INJURY OCCURRED			
45. LOCATION (Street and Number or Rural Route Number, City or Town, State)				46. DATE SIGNED (Month, Day, Year) May 12, 1995			
47. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
48. SIGNATURE AND TITLE OF CERTIFIER <u>Ziad Mirza, M.D.</u>				49. LICENSE NUMBER D41901		50. DATE SIGNED (Month, Day, Year) May 12, 1995	
51. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ziad Mirza, M.D. 3007 E. Northern Parkway Baltimore, MD 21214							
52. DATE FILED (Month, Day, Year) MAY 15 1995				53. REGISTRAR'S SIGNATURE <u>John Charles Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Sellman, Arthur B. Sellman</u>				2. DATE OF DEATH MONTH <u>5</u> DAY <u>13</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>2:10 P M</u>	
4. SOCIAL SECURITY NUMBER <u>216-24-2912</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>67</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>March 19, 1928</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Baltimore, MD</u>				9a. FACILITY NAME (If not institution, give street and number) <u>Johns Hopkins Bayview Medical Center</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>	
9c. COUNTY OF DEATH <u>N/A</u>				10a. STATE <u>Maryland</u>			
10b. COUNTY <u>N/A</u>				10c. CITY, TOWN OR LOCATION <u>Baltimore</u>			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <u>3829 Lyndale Avenue</u>			
10f. ZIP CODE <u>21213</u>				10g. CITIZEN OF WHAT COUNTRY? <u>United States</u>			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6</u> College (1-4 or 5+) <u></u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Surveyor's Helper</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Baltimore City</u>			
17. FATHER'S NAME (First, Middle, Last) <u>George J. Sellman</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Emma G. Brandt</u>			
19a. INFORMANT'S NAME (Type/Print) <u>James B. Sellman</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3814 Evergreen Ave. Baltimore, MD 21206</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Baltimore Cemetery</u>		20c. DATE <u>5/17</u>		20d. LOCATION — City or Town, State <u>Baltimore, Maryland</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Jeffrey L. Gair</u>				22. NAME AND ADDRESS OF FACILITY <u>Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Arrhythmia of Ventricle</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <u>Large Subdural Hematoma</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Fall Down Stairs</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>Seizure</u>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Epilepsy</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <u>5-13-95</u>		28b. TIME OF INJURY <u>10:30 AM</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <u>Seizure with fall down stairs</u>				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <u>Home</u>			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <u>3829 Lyndale Ave Balt. MD</u>				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <u>M. C. Wells, MD</u>				29c. LICENSE NUMBER <u>J7421</u>		29d. DATE SIGNED (Month, Day, Year) <u>5/13/95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>MARK WATTS Bayview Hospital</u>							
31. DATE FILED (Month, Day, Year) <u>MAY 15 1995</u>				32. REGISTRAR'S SIGNATURE <u>John A. Anderson-Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14761

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Anna Supniewski</b>				2. DATE OF DEATH MONTH <b>5</b> DAY <b>11</b> YEAR <b>95</b>		3. TIME OF DEATH <b>9:50 PM</b>	
4. SOCIAL SECURITY NUMBER <b>214-12-9203</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. mss. birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-15-13</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Bel Forest Nsg/Rehab Ctr</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Forest Hill</b>		9c. COUNTY OF DEATH <b>HARFORD</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>HARFORD</b>		10c. CITY, TOWN OR LOCATION <b>Bel Forest / Forest Hill</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>109 Forest Valley Dr</b>			
10f. ZIP CODE <b>21050</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8YRS</b> College (1-4 or 5+) <b>AT HOME</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>John Koon</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Josephine STYS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JUANITA G. Insley</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2100 ARABIAN COURT FALLSTON, MARYLAND 21047</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARDEN OF FAITH</b>		20c. LOCATION — City or Town, State <b>ROSEDALE MARYLAND</b>		20d. DATE <b>5-15-95</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>[Signature]</b>				22. NAME AND ADDRESS OF FACILITY <b>EVANS FUNERAL CHAPEL - BEL AIR, P.A. 2100 30 NEWPORT DRIVE FOREST HILL, MARYLAND</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Uremia</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimers</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>028339</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 12 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>LINDA FREELIGHT 101 E. Wheel Road Bel Air MD 21015</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1968 JAN 15



95 14762

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LUCILLE SCOTT</b>				2. DATE OF DEATH MONTH <b>5</b> DAY <b>10</b> YEAR <b>95</b>		3. TIME OF DEATH <b>7:30 A. M.</b>	
4. SOCIAL SECURITY NUMBER <b>240 09 8721</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2/21/15</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>2100 Penrose Ave.</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		8c. COUNTY OF DEATH	
9. RESIDENCE OF DECEDENT				10a. STATE <b>Md.</b>		10b. COUNTY	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>1100 Pennsylvania Ave.</b>				10f. ZIP CODE <b>21201</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>Domestic</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Home maker</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Harvey Bullock</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Annie Perry</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dorothy Thornton</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2100 Penrose Avenue Balto., Md. 21223</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Woodlawn</b>		20c. LOCATION — City or Town, State <b>Balto., Md.</b>		20d. DATE <b>5/15</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James A. Morton</b>				22. NAME AND ADDRESS OF FACILITY <b>James A. Morton &amp; Sons</b> <b>1701 Laurens St. Balto., Md. 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>ASCVD</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Hypertension</b> DUE TO (OR AS A CONSEQUENCE OF): <b>and Diabetes</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>12/19/94</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Peripheral vascular disease</b> <b>Peptic Ulcer Disease</b> <b>Glaucoma</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Thomas J. Lynch MD</b>				29c. LICENSE NUMBER <b>D 42196</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/11/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Thomas J. Lynch MD</b> <b>301 St. Paul #907 21202</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>		32. REGISTRAR'S SIGNATURE <b>John A. ...</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14763

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Charles Kenneth Shupe</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>12</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>1:30 p m</b>	
4. SOCIAL SECURITY NUMBER <b>230-24-9620</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>65</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 9, 1929</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1913 Suffolk Rd.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Finksburg</b>		9c. COUNTY OF DEATH <b>Carroll</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Arizona</b>		10b. COUNTY <b>Pima</b>		10c. CITY, TOWN OR LOCATION <b>Tucson</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1212 North Del Valle Place</b>				10f. ZIP CODE <b>85712</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II &amp; Korean</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Truck Driver</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Construction</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Fred D. Shupe</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Effie Lyons</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary Ann Shupe</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1212 North Del Valle Place, Tucson, Arizona 85712</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rose Lawn Cemetery May 16, 1995 Marion, Virginia</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>H. G. Eckhardt</i>		22. NAME AND ADDRESS OF FACILITY <b>Eckhardt Funeral Chapel 21117 11605 Reisterstown Rd., Owings Mills, Md.</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. METASTATIC ADENOCARCINOMA COLON</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <b>1 yr</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mack C. Mitchell, Jr. M.D.</i>				29c. LICENSE NUMBER <b>D23832</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/13/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MACK C. MITCHELL, JR. M.D., G.B.M.C. 6565 N. CHARLES ST. BALTO</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14764

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY G SHAFFER.</b>				2. DATE OF DEATH MONTH <b>5</b> DAY <b>12</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>8:30 PM</b>	
4. SOCIAL SECURITY NUMBER <b>212-01-8655</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 21, 1908</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9. FACILITY NAME (If not institution, give street and number) <b>Westminster Nursing &amp; Conv. Ctr.</b>		10. CITY, TOWN OR LOCATION OF DEATH <b>Westminster</b>	
11. RESIDENCE OF DECEDENT				12. COUNTY OF DEATH <b>Carroll</b>		13. STATE <b>Md.</b>	
14. STREET AND NUMBER <b>1234 Washington Rd.</b>		15. ZIP CODE <b>21157</b>		16. CITY, TOWN OR LOCATION <b>Westminster</b>		17. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
18. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		19. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Supervisor</b>		20. KIND OF BUSINESS/INDUSTRY <b>Clothing Factory</b>		21. DECEASED'S EDUCATION (Specify only highest grade completed) <b>10</b>	
22. DECEASED'S EDUCATION (Specify only highest grade completed) <b>10</b>		23. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Supervisor</b>		24. KIND OF BUSINESS/INDUSTRY <b>Clothing Factory</b>		25. DECEASED'S EDUCATION (Specify only highest grade completed) <b>10</b>	
17. FATHER'S NAME (First, Middle, Last) <b>George Washington Shaffer</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Annie Armetta Nusbaum</b>			
19. INFORMANT'S NAME (Type/Print) <b>Charles O. Fisher</b>				20. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>179 E. Main St., Westminster, Md. 21157</b>			
21. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		22. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Old Lutheran Cem. 5-16-1995</b>		23. DATE <b>5-16-1995</b>		24. LOCATION - City or Town, State <b>Manchester, MD.</b>	
25. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>J. Hartl Eschardt</i>				26. NAME AND ADDRESS OF FACILITY <b>Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester, MD. 21102</b>			
27. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebral vascular insufficiency</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Cerebral vascular hemorrhage</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Hypertension</b> DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>18 MONTHS</b> <b>6 YEARS</b> <b>10 YEARS</b>							
28. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
29. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		30. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
31. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		32. DATE OF INJURY (Month, Day, Year)		33. TIME OF INJURY <b>M</b>		34. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
35. DESCRIBE HOW INJURY OCCURRED		36. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		37. LOCATION (Street and Number or Rural Route Number, City or Town, State)		38. DATE SIGNED (Month, Day, Year) <b>5-12-95</b>	
39. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
40. SIGNATURE AND TITLE OF CERTIFIER <i>Daniel I. Welliver M.D.</i>				41. LICENSE NUMBER <b>D11496</b>		42. DATE SIGNED (Month, Day, Year) <b>5-12-95</b>	
43. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DANIEL I. WELLIVER 912 WASHINGTON ROAD WESTMINSTER MD 21157</b>							
44. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				45. REGISTRAR'S SIGNATURE <i>John Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

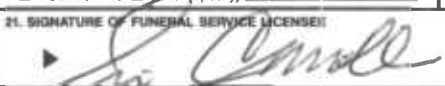
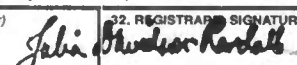
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14765

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Delia Morton Scott</b>				2. DATE OF DEATH MONTH <b>5</b> DAY <b>6</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>11:30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>213-12-2734</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>90</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>12/30/1904</b>	8. BIRTHPLACE (State or Foreign Country) <b>VIRGINIA</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>Pleasant Manor Nursing Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>1020 E. Biddle Street</b>				10f. ZIP CODE <b>21202</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>UNKNOWN</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DOESMITC WORKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOUSE CLEANING</b>			
17. FATHER'S NAME (First, Middle, Last) <b>MORTY MORTON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>UNKNOWN/UNKNOWN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>DELORES LAURENCE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1739 N. MONTPLIER STREET</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. ZION</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>IRVIN CARROLL FUNERAL HOME 1712 W. NORTH AVENUE</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acute myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <b>b. arteriosclerotic heart disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. peripheral vascular disease - femoral &amp; tibial arteries</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>							Approximate Interval Between Onset and Death <b>1 day</b> <b>4 yrs</b> <b>2 yrs</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>diagnosed brain disease, stroke 1/12 depression hypothyroidism</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>N/A</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED <b>N/A</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>N/A</b>			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Manuel Levin M.D.</b>				29c. LICENSE NUMBER <b>D05622</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/19/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Manuel Levin, M.D., 6101 Park Heights Ave., Baltimore, MD 21215</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14766

1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RUTH SILVERNAIL				2. DATE OF DEATH MONTH DAY YEAR May 10 1995		3. TIME OF DEATH 6:15 P M	
4. SOCIAL SECURITY NUMBER 215-54-0321		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 38 YRS.		7. DATE OF BIRTH MONTH DAY YEAR September 27 1956	
9a. FACILITY NAME (If not institution, give street and number) Howard County General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Columbia		9c. COUNTY OF DEATH Howard County	
10a. STATE Maryland				10b. COUNTY Howard County		10c. CITY, TOWN OR LOCATION Ellicott City	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 4536 Kingscup Court				10f. ZIP CODE 21042		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Computer Trainer		16b. KIND OF BUSINESS/INDUSTRY Government Contracting			
17. FATHER'S NAME (First, Middle, Last) Charles Silvernail				18. MOTHER'S NAME (First, Middle, Maiden Surname) Phyllis Fuller			
19a. INFORMANT'S NAME (Type/Print) Ms. Tamar Jones				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4536 Kingscup Court, Ellicott City, MD 21042			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Camptown Cemetery 5/13/95		20c. LOCATION — City or Town, State Camptown, PA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Phyllis Fuller</i> M00535				22. NAME AND ADDRESS OF FACILITY Slack Funeral Home, P.A. Ellicott City, Maryland 21043			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): b. Aspiration pneumonia DUE TO (OR AS A CONSEQUENCE OF): c. Adenocarcinoma of lung Stage IV DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 3 days 5 days 11 months							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. S/P Radiation to chest, COPD Chronic anemia, SVC syndrome DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide 4 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jon Minford M.D.</i>				29c. LICENSE NUMBER D30573		29d. DATE SIGNED (Month, Day, Year) May 12, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jon Minford, M.D. 11065 Little Patuxent Parkway, Columbia, MD 21044							
31. DATE FILED (Month, Day, Year) MAY 15 1995				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14767

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY TINDAL</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>08</b> YEAR <b>95</b>		3. TIME OF DEATH <b>1400 M</b>	
4. SOCIAL SECURITY NUMBER <b>250-38-5476</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 12, 1926</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>UNION MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>South Carolina</b>		10b. COUNTY <b>Clarendon</b>		10c. CITY, TOWN OR LOCATION <b>Summerton</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>P.O. Box 755 - Washington St.</b>				10f. ZIP CODE <b>29148</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>8</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Farmer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Self</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Carrigan Mouzon</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Clara Bell Blackwell</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Deloris Tindal</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 755, Summerton, S.C. 29148</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Taw Caw Baptist Ch. Cem.</b>		20c. LOCATION — City or Town, State <b>Summerton, S.C.</b>		20d. LOCATION — City or Town, State <b>Summerton, S.C.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>ALTENBURG FUNERAL HOME, P.A. 6009 Harford Rd., Baltimore, MD 21214</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Renal failure</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Renal Cell Carcinoma</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b></b> DUE TO (OR AS A CONSEQUENCE OF): d. <b></b> Approximate interval Between Onset and Death <b>22 yrs.</b> <b>12 mos</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>hypertension, congestive heart failure, stroke, peripheral vascular disease, seizure disorder</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> <b>M.D.</b>				29c. LICENSE NUMBER <b>646574</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/8/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ANDREW B. REISMAN, M.D.</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MATTHEW G. THOMAS</b>				2. DATE OF DEATH MAY 07 1995		3. TIME OF DEATH 22:20 M					
4. SOCIAL SECURITY NUMBER 213-31-8872		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 4 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10 16 90		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BERLIN			9c. COUNTY OF DEATH WORCESTER				
10a. STATE MARYLAND		10b. COUNTY WORCESTER		10c. CITY, TOWN OR LOCATION OCEAN CITY			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER 8904 RUSTY ANCHOR ROAD APT:#225				10f. ZIP CODE 21842		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A		16. KIND OF BUSINESS/INDUSTRY N/A							
17. FATHER'S NAME (First, Middle, Last) MATTHEW A. THOMAS				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARIEL A. SLACK							
19a. INFORMANT'S NAME (Type/Print) MARIEL A. THOMAS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21842-8584 8904 RUSTY ANCHOR RD-#225-OCEAN CITY, MD.							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY, INC. 5/12		20c. LOCATION — City or Town, State CATONSVILLE, MD.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Darryl L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD.							
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Drowning</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 5/7/95		28b. TIME OF INJURY Early PM		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED subject drowned			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) new pier		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 225 Bridgeport Rusty Anchor							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King</i>				29c. LICENSE NUMBER O-CME		29d. DATE SIGNED (Month, Day, Year) MAY 07, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 27 (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) MAY 15 1995		32. REGISTRAR'S SIGNATURE <i>John D. ...</i>									



95 14769

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JESSIE THOMPSON</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>30</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>4:35 A M</b>	
4. SOCIAL SECURITY NUMBER <b>219-20-6615</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 17, 1906</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Howard County General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Columbia</b>		9c. COUNTY OF DEATH <b>Howard County</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Howard County</b>		10c. CITY, TOWN OR LOCATION <b>Ellicott City</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3102 Ramblewood Road</b>				10f. ZIP CODE <b>21042</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (13-16) <b>5+</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Bookkeeper</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Department Store</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Victor David Myers</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Susan Jane Gossard</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ms. Susan M. Thompson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3102 Ramblewood Road, Ellicott City, Maryland 21042</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b> <b>5/3/95</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Slack Funeral Home, P.A.</b> <b>Ellicott City, Maryland 21043</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PULMONARY EDEMA</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> b. <b>ACUTE RENAL FAILURE</b> c. <b>MALNUTRITION</b>							Approximate Interval Between Onset and Death <b>1 WEEK</b> <b>1 WEEK</b> <b>1 MONTH</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ATRIAL FIBRILLATION, STROKE, HYPERTENSION</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D38296</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 30, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOSEPH GIBBONS, MD 9501 OLD ANNAPOLIS ROAD, ELLICOTT CITY, MD 21042</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14770

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) <u>Elsa J. Vallalta</u>				2. DATE OF DEATH MONTH <u>May</u> DAY <u>12th</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>10:12 P</u> M	
4. SOCIAL SECURITY NUMBER <u>266-65-6421</u>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>79</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>5 5 1916</u>	
8a. FACILITY NAME (If not institution, give street and number) <u>Harbor Hospital</u>				8b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>		8c. COUNTY OF DEATH <u>N/A</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>Maryland</u>		10b. COUNTY <u>N/A</u>		10c. CITY, TOWN OR LOCATION <u>Baltimore</u>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>1807 Clifton Avenue</u>				10f. ZIP CODE <u>21217</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: <u>Hondurian</u>		14. RACE — American Indian, Black, White, etc. Specify: <u>Hondurian</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>N/A</u> Elementary/Secondary (0-12) <u>College (1-4 or 5+)</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Housekeeper</u>		16b. KIND OF BUSINESS/INDUSTRY <u>House Cleaning</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Leovieildo Yanes</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Martina Manzanares</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Louis Yanes</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1807 Clifton Avenue Baltimore, Maryland</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Honduras</u> <u>5-19</u>		20c. LOCATION — City or Town, State <u>Honduras</u>		20d. LOCATION — City or Town, State <u>U.S.A.</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <u>Irvin Carroll Funeral Home</u> <u>U.S.A.</u> <u>1712W. North Avenue Balt. Maryland 21217</u>			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Metastatic Disease</u> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; align-items: center;"> <div style="font-size: 3em; margin-right: 10px;">{</div> <div> <p><u>Undifferentiated Ovarian Cancer</u></p> <p><u>Hypertension</u></p> </div> </div>				Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension</u>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <u>N/A</u>		28b. TIME OF INJURY <u>N/A</u> M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED <u>N/A</u>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <u>N/A</u>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <u>N/A</u>	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Changian Chen, MD</u>				29c. LICENSE NUMBER <u>D-81174</u>		29d. DATE SIGNED (Month, Day, Year) <u>May 12th, 1995</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Changian Chen, 7888 Americana Circle #101, Glen Burnie, MD 21060</u>							
31. DATE FILED (Month, Day, Year) <u>MAY 15 1995</u>				32. REGISTRAR'S SIGNATURE			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14771

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Sally A. Veitch</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>10</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>5:35 P.</b> M	
4. SOCIAL SECURITY NUMBER <b>577-16-7331</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	8. AGE (In yrs. last birthday) <b>74</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 30, 1920</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>3621 Ligon Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Ellicott City</b>		9c. COUNTY OF DEATH <b>Howard</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Howard</b>		10c. CITY, TOWN OR LOCATION <b>Ellicott City</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3621 Ligon Road</b>				10f. ZIP CODE <b>21042</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Secretary</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Local Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Robert E. Worsley</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ruth Marie MacIntosh</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Edward H. Veitch (Spouse)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3621 Ligon Road Ellicott City, Maryland 21042</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cretslawn Cemetery May 15, 1995</b>		20c. LOCATION — City or Town, State <b>Marriottsville, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Leroy M &amp; Russell C Witzke Funeral Homes 1630 Edmondson Avenue Catonsville Maryland</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>LOBAR PNEUMONIA</b>					Approximate Interval Between Onset and Death <b>1 MONTH</b>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>BRONCHIOGENIC CARCINOMA</b>					<b>3 MONTHS</b>
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
		e. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Scott T Maurer MD</i>				29c. LICENSE NUMBER <b>D29909</b>		29d. DATE SIGNED (Month, Day, Year) <b>5-11-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SCOTT T MAURER 9501 OLD ANNAPOLIS RD ELLICOTT CITY MD 21042</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

5

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KALEB WINFIELD</b>				2. DATE OF DEATH MONTH <b>5</b> / DAY <b>7</b> / YEAR <b>95</b>		3. TIME OF DEATH <b>1:40 AM</b>	
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	8. AGE (In yrs. last birthday) YRS. <b>0</b> MONTHS <b>12</b> DAYS <b>12</b> HOURS <b>0</b> MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>5/6/95</b>		6. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>
9a. FACILITY NAME (If not institution, give street and number) <b>22 S. Greene University of MD Med. System Street</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH	
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Leslie Winfield</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Leslie Winfield</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12728 Stottlenyer Road, Myersville, MD 21773</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>in state</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald Wade, Dir.</b> <i>Ronald Wade</i>				22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board</b> <b>655 West Baltimore St., Balto., MD 21201</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Respiratory distress syndrome</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Pulmonary Interstitial Emphysema</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Extreme Prematurity - 24 wk.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>							Approximate interval Between Onset and Death <b>12 hours</b> <b>5 hours</b> <b>12 hours</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. J. H. Gwolski</i>				29c. LICENSE NUMBER <b>D39222</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/7/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>IRA H. GWOLSKI, MD - UMMS NEW 22 S. GREENE ST. BALTIMORE MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <i>John J. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14773

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Nettie -- Waites</b>				2. DATE OF DEATH MONTH DAY YEAR <b>5 8 95</b>		3. TIME OF DEATH <b>7.45 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>220-30-0808</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11/09/10</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Pleasant Manor Nursing Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>n/a</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1225 Poplar Grove Street</b>				10f. ZIP CODE <b>21216</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>High School.</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Domestic Work</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Katz-Berry Family</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Dorsey Walters, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sarah Lee</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Robert Walters</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1704 Randall Avenue Bronx, New York 10473</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Western Star Cemetery</b>		20c. LOCATION — City or Town, State <b>May 12 Baltimore, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Kevin Parker</b>				22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CONGESTIVE HEART FAILURE</b> DAYS a. DUE TO (OR AS A CONSEQUENCE OF): b. <b>ARTERIOCLEROTIC HEART DISEASE</b> YEARS c. DUE TO (OR AS A CONSEQUENCE OF): d.  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b>							Approximate Interval Between Onset and Death
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>B. C. Veneracion MD</b>				29c. LICENSE NUMBER <b>D13664</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/8/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>B.C. Veneracion, MD. 1576 Merritt Boulevard, Suite 22, Baltimore, MD. 21222</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <b>J. B. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14774

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>11</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>9:50 P M</b>	
4. SOCIAL SECURITY NUMBER <b>220-26-2475</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7. DATE OF BIRTH (Month, Day, Year) <b>JULY 9, 1926</b>				8. BIRTHPLACE (State or Foreign Country) <b>S.C.</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>ST. AGNES HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1907 RIGGS AVE.</b>				10f. ZIP CODE <b>21217</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+) <b>N/A</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>RECEIVING CLERK</b>				16b. KIND OF BUSINESS/INDUSTRY <b>SMITH BAKERY</b>	
17. FATHER'S NAME (First, Middle, Last) <b>THOMAS WELLS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>DELLA TRUESDALE</b>					
19a. INFORMANT'S NAME (Type/Print) <b>DIREATHER E. LEMMON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>104 DIENER PLACE #304 BALTO. MD 21229</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CEDAR HILL CEMETERY 5-15-95</b>				20c. LOCATION — City or Town, State <b>BALTO. MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Allyn B. Scott</i>				22. NAME AND ADDRESS OF FACILITY <b>MARCH FUNERAL HOME-WEST 4300 WABASH AV. BALTO. MD 21215</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Prostate Cancer</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.				Approximate Interval Between Onset and Death <b>6 months</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard Baker</i>				29c. LICENSE NUMBER <b>MD 44404</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 11, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Richard Baker St Agnes Hospital</b>				31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1958-1959

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95 14775

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROBERT L. WALL</b>				2. DATE OF DEATH MONTH <b>05</b> DAY <b>11</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>1245A</b>	
4. SOCIAL SECURITY NUMBER <b>217-22-1000</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JAN 1 1926</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>PLEASANT MANOR N.H. 4615 PARKHEAGHTS AVE.</b>			
10f. ZIP CODE <b>21215</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>6-13-44 -- 5-16-46</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>NA</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Presser</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Tailor Shop</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JAMES WALL</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CARRIE ALLEN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ARTHUR L. WALL</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11073 SWANSFIELD RD COLUMBIA, MD 21044</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARRISON FOREST VETERAN CEM. 51695</b>		20c. LOCATION — City or Town, State <b>OWINGS MILLS, MD</b>		20d. DATE <b>5/11/95</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>MARCH FUNERAL HOME-WEST 4300 WABASH AVE. BALTO., MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <b>1wk</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension, multiple cerebrovascular accidents seizure disorder</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Anil K Dubey</i> PGY-1 Resident				29c. LICENSE NUMBER <b>PA5 9820</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/11/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ANIL K. DUBEY, MD SINAI HOSPITAL OF BALTIMORE BALTIMORE, MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

5X1

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>William Charles Winterling</i>				2. DATE OF DEATH MONTH <i>05</i> DAY <i>11</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>9 30 A.M.</i>	
4. SOCIAL SECURITY NUMBER <i>215-30-9444</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>63</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Jan. 25, 1932</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Johns Hopkins Bayview Medical Ctr.</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>		9c. COUNTY OF DEATH <i>N/A</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Dundalk</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>3216 Old North Point Road</i>				10f. ZIP CODE <i>21222</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>1955-1959</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) <i>4 Years</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Chemist</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Paint Industry</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Frank J. Winterling</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Louise Gross</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mr. William Winterling</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3216 Old North Pt. Road Dundalk, MD 21222</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Sacred Ht. of Jesus Cem. 5/13/95</i>		20c. LOCATION — City or Town, State <i>Dundalk, Maryland</i>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph E. Reed</i>	
22. NAME AND ADDRESS OF FACILITY <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Subarachnoid hemorrhage</i>					
		b. <i>cerebral aneurysm</i>					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. <i></i>					
		d. <i></i>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>peripheral vascular disease, anoxic encephalopathy, HTN, CAD, H/O cardiac arrest</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>Ellen Deibert MD</i>		29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER <i>95041</i>		29d. DATE SIGNED (Month, Day, Year) <i>5/11/1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Ellen Deibert JHH Dept Neurology, Baltimore MD</i>							
31. DATE FILED <i>MAY 15 1995</i>		32. REGISTRAR'S SIGNATURE <i>John A. Deibert</i>					

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be retained by the funeral director. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



95 14777

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Dorothy G. Walter</i>				2. DATE OF DEATH MONTH <i>May</i> DAY <i>06</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>3:50</i> M	
4. SOCIAL SECURITY NUMBER <i>519-09-2292</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>83</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Dec 27, 1911</i>	
8a. FACILITY NAME (If not Institution, give street and number) <i>FALLSTON General Hospital</i>				8b. CITY, TOWN OR LOCATION OF DEATH <i>FALLSTON</i>		8c. COUNTY OF DEATH <i>Hartford</i>	
10a. STATE <i>Md.</i>				10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>MONKTON</i>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <i>16305 YORK Rd.</i>		10f. ZIP CODE <i>21111</i>	
10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <i>12</i> College (1-4 or 8+) <i>2</i>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Home</i>		17. FATHER'S NAME (First, Middle, Last) <i>THOMAS KNOX Greer</i>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>LAURA THERNEAU</i>				19a. INFORMANT'S NAME (Type/Print) <i>JOHN Walter</i>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>16305 YORK Rd. MONKTON, Md. 21111</i>	
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Green Mount Cemetery</i>		20c. LOCATION — City or Town, State <i>Balto. Md</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles F. Evans</i>				22. NAME AND ADDRESS OF FACILITY <i>EVANS Funeral Chapel - Bel Air 3 NEWPORT DR. Forest Hill, Md. 21050</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>CONGESTIVE HEART FAILURE</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
<i>ASPIRATION PNEUMONIA</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
<i>INSULIN-DEPENDENT DIABETES MELLITUS</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
Approximate Interval Between Onset and Death <i>3 MONTHS</i>							
Approximate Interval Between Onset and Death <i>4 DAYS</i>							
Approximate Interval Between Onset and Death <i>15 YEARS</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>POLYCYTHEMIA VERA</i> <i>PROTEIN-CALORIE MALNUTRITION</i>							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Andrew Nowakowski MD</i>				29c. LICENSE NUMBER <i>D9095</i>		29d. DATE SIGNED (Month, Day, Year) <i>MAY 9, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>ANDREW NOWAKOWSKI, MD 125 N. MAIN ST BELAIR, MD 21014</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 15 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Andrew...</i>			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION





95 14778

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY ELIZABETH WOLF</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 13, 1995</b>		3. TIME OF DEATH HOURS MIN. SEC. <b>3AM</b>					
4. SOCIAL SECURITY NUMBER <b>183-12-5619</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. <b>72</b>		7. DATE OF BIRTH (Month, Day, Year) <b>AUG 21, 1922</b>		8. BIRTHPLACE (State or Foreign Country) <b>PENNSYLVANIA</b>			
9a. FACILITY NAME (If not Institution, give street and number) <b>6A Lockhart Circle</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>FOREST HILL</b>				9c. COUNTY OF DEATH <b>HARFORD</b>			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>HARFORD</b>		10c. CITY, TOWN OR LOCATION <b>FOREST HILL</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>6A Lockhart Circle</b>				10f. ZIP CODE <b>21050</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12YRS.</b> College (14 or 5+) <b>BYRS.</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>AT HOME</b>				16b. KIND OF BUSINESS/INDUSTRY <b>HOUSEWIFE</b>					
17. FATHER'S NAME (First, Middle, Last) <b>MICHAEL KANE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>RUTH PATTERSON</b>							
19a. INFORMANT'S NAME (Type/Print) <b>J. RICHARD WOLF</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6A Lockhart Circle Forest Hill, Maryland 21050</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BEL AIR MEMORIAL</b>		OATE <b>5-15</b>		20c. LOCATION — City or Town, State <b>BEL AIR, Maryland</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>[Signature]</b>				22. NAME AND ADDRESS OF FACILITY <b>EVANS FUNERAL HOME - BEL AIR, P.A. 31 NEWPORT DRIVE FOREST HILL, MARYLAND</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Posterior Meningeal Carcinoma</b> <b>Infiltrating Squamous cell carcinoma</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Tobacco dependent diabetes mellitus</b>								Approximate Interval Between Onset and Death			
24. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY HOURS MIN. SEC. <b>N/A</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>N/A</b>			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>N/A</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>N/A</b>					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>						29c. LICENSE NUMBER <b>D38933</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 15, 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. ROBERT S. KNIGHT 104 Plumtree Road BEL AIR, MARYLAND</b>											
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14779

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM T. WRIGHT</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>9</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>7:10 am</b>	
4. SOCIAL SECURITY NUMBER <b>140-20-8745</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct 1, 1927</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Saint Joseph Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson, Maryland</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Md</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Parkville</b>				10d. INSIDE CITY LIMITS? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>8 MAPLE HOLLOW CT</b>	
10f. ZIP CODE <b>21234</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Sales</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Sales-WR GRACE</b>			
17. FATHER'S NAME (First, Middle, Last) <b>GEORGE D. WRIGHT SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNA E.M. Mc NINNEY</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Colleen A. EYLER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8 MAPLE HOLLOW CT Balto. Md. 21234</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>PARKWOOD Cemetery</b>		20c. LOCATION — City or Town, State <b>Parkville, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert L. Jones</i>				22. NAME AND ADDRESS OF FACILITY <b>EVANS CHAPEL OF MEMORIES</b> <b>8800 HARFORD Rd Balto. Md. 21234</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RECTAL CANCER WITH METASTASES</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) <b>HOSPITAL:</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA <b>OTHER:</b> <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Natividad D. de Leon, M.D.</i>				29c. LICENSE NUMBER <b>D 19508</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 9, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>NATIVIDAD D. DELEON, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>		32. REGISTRAR'S SIGNATURE <i>John A. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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ANTONIO D. DELEON M.D. 1820 YORK ROAD TOWSON, MARYLAND 21204

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Gilbert J. Weis				2. DATE OF DEATH MONTH DAY YEAR May 11, 1995		3. TIME OF DEATH 7:25 A. M	
4. SOCIAL SECURITY NUMBER 213-01-3897		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 87 YRS.	7. DATE OF BIRTH (Month, Day, Year) 1-21-1908		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Meridian Multi Medical				9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Towson		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 915 Radcliffe Road				10f. ZIP CODE 21204		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Captain		16b. KIND OF BUSINESS/INDUSTRY Baltimore County Fire Dept.			
17. FATHER'S NAME (First, Middle, Last) John G. Weis				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary E. Gilbert			
19a. INFORMANT'S NAME (Type/Print) David D. Downes				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Allegheny Ave., Towson, Maryland 21204			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland Memorial Cemetery		20c. LOCATION — City or Town, State 5-15-95 Parkville, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wallace S. Brooks, Jr.				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung carcinoma Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST 1. DUE TO (OR AS A CONSEQUENCE OF): 2. DUE TO (OR AS A CONSEQUENCE OF): 3. DUE TO (OR AS A CONSEQUENCE OF): 4. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 3 weeks
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Francis Carmody, M.D.				29c. LICENSE NUMBER D01373		29d. DATE SIGNED (Month, Day, Year) 5/11/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Francis Carmody, M.D. 7505 Osler Drive, Towson, Maryland 21204							
31. DATE FILED (Month, Day, Year) MAY 15 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) MUKHTAR AHMAD YOUSAFE				2. DATE OF DEATH MAY 13 1995		3. TIME OF DEATH 8:09 A M					
4. SOCIAL SECURITY NUMBER UNKNOWN		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 30 YRS.		7. DATE OF BIRTH (Month, Day, Year) JANUARY 12, 1965		8. BIRTHPLACE (State or Foreign Country) KANDAHAR			
9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY			9c. COUNTY OF DEATH PRINCE GEORGES				
10a. STATE VIRGINIA		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION FAIRFAX			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				
10e. STREET AND NUMBER 9136 BARRICK ST. APT 302				10f. ZIP CODE 22031		10g. CITIZEN OF WHAT COUNTRY? AFGHANISTAN					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: ASIAN				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MECHANIC		16b. KIND OF BUSINESS/INDUSTRY Auto Body							
17. FATHER'S NAME (First, Middle, Last) MOHAMMED QASIM YOUSAFI				18. MOTHER'S NAME (First, Middle, Maiden Surname) FATIMA YOUSAFI							
19a. INFORMANT'S NAME (Type/Print) SAKHI YOUSAFI				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9136 BARRICK ST. #302							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KASSI CEMETERY 5/14 QUETTA, PAKISTAN			20c. LOCATION — City or Town, State QUETTA, PAKISTAN						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Chandler, Deborah				22. NAME AND ADDRESS OF FACILITY MANASSAS VA. BLASIUS - BAKER Funeral Home							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Injuries DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 5/13/95		28b. TIME OF INJURY 538 A.M.		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED motor vehicle collision			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) street				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Rt 495 North of Rt 201 Knox Hill, P.G. Co. Md							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Dennis J. Chute MD						29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) MAY 14, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) MAY 15 1995				32. REGISTRAR'S SIGNATURE John Andrew Kattell							





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <del>MERLE</del> MINNIE MERLE YODER				2. DATE OF DEATH MONTH DAY YEAR MAY 12 1995		3. TIME OF DEATH 2:15 A.M.	
4. SOCIAL SECURITY NUMBER 212-38-0223		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2/3/04	
9a. FACILITY NAME (If not institution, give street and number) ST. JOSEPH HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH TOWSON		9c. COUNTY OF DEATH BALTIMORE	
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Towson	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 204 E. Joppa Road Apt. 1102				10f. ZIP CODE 21286		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Yrs		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Librarian		16b. KIND OF BUSINESS/INDUSTRY Towson State Univ.			
17. FATHER'S NAME (First, Middle, Last) Solomon Moses Yoder				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eliza Wolfe			
19a. INFORMANT'S NAME (Type/Print) John Edward Shinnars				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1141 Gypsy Lane East Towson, MD 21286			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 5/13/95		20c. LOCATION — City or Town, State Catonsville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Christina S. Kopczyk</i>				22. NAME AND ADDRESS OF FACILITY JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD TOWSON, MD 21286			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Aortic stenosis</u> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate interval Between Onset and Death Years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>pernicious anemia</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER <i>Evangelos C. Lignos M.D.</i>				29c. LICENSE NUMBER D19589		29d. DATE SIGNED (Month, Day, Year) 5.12.95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) EVANGELOS C. LIGNOS, 7801 YORK RD TOWSON MD 21204							
31. DATE FILED (Month, Day, Year) MAY 15 1995		32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Lawrence Ambush</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 13, 1995</b>		3. TIME OF DEATH <b>9:10 am</b>	
4. SOCIAL SECURITY NUMBER <b>520-44-9184</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>60</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 5, 1935</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>7209 Chalkstone Dr Apt T1</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>NA</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>NA</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7209 Chalkstone Drive Apt T1</b>				10f. ZIP CODE <b>21208</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+) <b>5+</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Attorney</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Law</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Joseph D Ambush</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Arline Marchik</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Rena A Levin</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7117 Boxford Road Baltimore, MD 21215</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of other place) <b>Shearith Shearith-Israel May 14, 1995</b>		20c. LOCATION — City or Town, State <b>Baltimore MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACUTE MYELOBLASTIC LEUKEMIA (RECURSED) 7/95</b>							Approximate Interval Between Onset and Death <b>18 mos</b>
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>William A Flood MD</b>				29c. LICENSE NUMBER <b>D 44682 (MD)</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/14/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>WILLIAM A. FLOOD, MD; THE JOHNS HOPKINS ONCOLOGY CTR; Baltimore MD 21287</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14784

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Solomon E. Bolding Jr.				2. DATE OF DEATH MONTH DAY YEAR May 14 1995		3. TIME OF DEATH 6:30p M	
4. SOCIAL SECURITY NUMBER 219-32-8379		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 57 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 9, 1937	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 1703 Latrobe		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH N/A				10a. STATE Md.		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 4019 Dorchester Rd.	
10f. ZIP CODE 21207				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver		16b. KIND OF BUSINESS/INDUSTRY Trucking	
17. FATHER'S NAME (First, Middle, Last) Solomon Bolding Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mattie Phillips			
19a. INFORMANT'S NAME (Type/Print) Leona F. Bolding				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4019 Dorchester Rd. Baltimore, Md. 21207			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Nat. Cem. 5-19-95		20c. LOCATION — City or Town, State Laurel, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kerwin R. Bailey				22. NAME AND ADDRESS OF FACILITY Douglass Funeral Service 1701 McCulloch St.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive heart failure							
b. alcoholism							
c. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Daniel P. Judge, MD				29c. LICENSE NUMBER 69711		29d. DATE SIGNED (Month, Day, Year) 5/16/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Daniel P. Judge, MD Tindico Ulhart Med Ctr, 2809 Boston St, Baltimore							
31. DATE FILED (Month, Day, Year) MAY 16 1995				32. REGISTRAR'S SIGNATURE John D. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14785

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edward Walter BOCHNIAK				2. DATE OF DEATH May 14, 1995		3. TIME OF DEATH 4:45 a.m.	
4. SOCIAL SECURITY NUMBER 215-10-7797		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT. 13, 1906	
9a. FACILITY NAME (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH Baltimore	
10a. STATE N. CAROLINA				10b. COUNTY DAVIDSON		10c. CITY, TOWN OR LOCATION LEXINGTON	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 1812 LEXINGTON STREET (EXT LEXINGTON)			
10f. ZIP CODE 27292				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH GRADE College (1-4 or 8+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LONG SHOREMAN		16b. KIND OF BUSINESS/INDUSTRY STEAMSHIP			
17. FATHER'S NAME (First, Middle, Last) JACOB BOCHNIAK				18. MOTHER'S NAME (First, Middle, Maiden Surname) CARRIE ROUG			
19a. INFORMANT'S NAME (Type/Print) MRS. DORIS RAUBAUGH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5404 CEDONIA AVENUE - BALTIMORE, MD 21206			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) FOREST HILL		DATE 5/17		20c. LOCATION — City or Town, State LEXINGTON, N.C.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jackie H. Shannon</i>				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Acute Myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Arteriosclerotic cardiovascular disease</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ _____							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Laurie Harris</i>				29c. LICENSE NUMBER D26116		29d. DATE SIGNED (Month, Day, Year) May 16, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Laurie Harris, M.D. 9000 Franklin Square Drive Balt. MD 21237							
31. DATE FILED (Month, Day, Year) MAY 16 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14786

Items#6.7. G film 723 per F.H 5/16/95 P.C

1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JEROME J. BROUWER</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>11</b> , YEAR <b>1995</b>		3. TIME OF DEATH <b>4:25</b> P M							
4. SOCIAL SECURITY NUMBER <b>314-38-3306</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>58</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1939</b> <b>January 27, 1939</b>							
8. BIRTHPLACE (State or Foreign Country) <b>Indiana</b>				9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>							
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>Ohio</b>		10b. COUNTY <b>Green</b>							
10c. CITY, TOWN OR LOCATION <b>Bellbrook</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>3041 Rising Springbrook</b>							
10f. ZIP CODE <b>45305</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced							
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Engineer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Electronics Mfg.</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Wayne J. Brouwer</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Connie Johnson</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Judy Brouwer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3041 Rising Springbrook, Bellbrook, OH 45305</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Catholic Cemetery</b> <b>5/17</b>		20c. LOCATION — City or Town, State <b>Fort Wayne, Indiana</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gary L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY <b>Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227</b>									
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Circulatory collapse</b> Approximate Interval Between Onset and Death <b>Minutes</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <table border="1"> <tr> <td><b>d. Sepsis / Disseminated intravascular coagulation</b></td> <td><b>Weeks</b></td> </tr> <tr> <td><b>c. Atherosclerotic infarction / Perforation</b></td> <td><b>Weeks</b></td> </tr> <tr> <td><b>b. Benign prostatic disease</b></td> <td><b>Months</b></td> </tr> </table>								<b>d. Sepsis / Disseminated intravascular coagulation</b>	<b>Weeks</b>	<b>c. Atherosclerotic infarction / Perforation</b>	<b>Weeks</b>	<b>b. Benign prostatic disease</b>	<b>Months</b>
<b>d. Sepsis / Disseminated intravascular coagulation</b>	<b>Weeks</b>												
<b>c. Atherosclerotic infarction / Perforation</b>	<b>Weeks</b>												
<b>b. Benign prostatic disease</b>	<b>Months</b>												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)									
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)													
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D.				29c. LICENSE NUMBER <b>M5395</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/11/95</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. G. L. Roseborough, 950 Fairmount Ave., Towson, MD</b>													
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14787

Item 1, Film, 723, 5/16/95, 1t

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BARBARA JUANNE BRITTAIN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 15th 1995</b>		3. TIME OF DEATH <b>10:45 AM</b>	
4. SOCIAL SECURITY NUMBER <b>218-28-1231</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>61</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8-26-33</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>RANDALLSTOWN</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>BALT.</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>6504 LENNETT ST.</b>	
10f. ZIP CODE <b>21207</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8th</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Cashier/Office Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Grocery Store</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Robert Leroy Zerrlaut</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Della Blanche Kane</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Charles Edward Brittain, III</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>610 Glynock Place Reisterstown, MD 21136</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 05/16/95</b>		20c. LOCATION — City or Town, State <b>Baltimore</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Dawn F. McDonald</b>				22. NAME AND ADDRESS OF FACILITY <b>Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lung Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>One month</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> 5 Residence <input type="checkbox"/> 6 Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>K.S. RAD. M.D.</b>				29c. LICENSE NUMBER <b>043462</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 15th 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>K.S. RAD. M.D. NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Decker Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 14788

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elizabeth R. Brown				2. DATE OF DEATH MONTH DAY YEAR May 13, 1995		3. TIME OF DEATH 17:55 P.M.	
4. SOCIAL SECURITY NUMBER 215-28-7757		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 9, 1915	
9a. FACILITY NAME (If not institution, give street and number) Harbor Hospital Center				9b. CITY, TOWN OR LOCATION OF DEATH Balto. City, Md.		9c. COUNTY OF DEATH none	
10a. STATE Maryland				10b. COUNTY A.A. Co.		10c. CITY, TOWN OR LOCATION Glen Burnie, Md.	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 369 Dublin Dr.				10f. ZIP CODE 21060		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4th Grade		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		15b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) George W. Poole				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Elizabeth Washington			
19a. INFORMANT'S NAME (Type/Print) Mr. James H. Brown				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 369 Dublin Dr. Glen Burnie, Md. 21060			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 5/15/1995		20c. LOCATION — City or Town, State Catonsville, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Daniel A. Taylor</i>				22. NAME AND ADDRESS OF FACILITY Balto. Md. 21225 Ave. McCully Funeral Home 237 E. Patapsco			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Sepsis</i>							
b. <i>Pneumonia</i>							
c. <i>Chronic Obstructive Pulmonary Disease</i>							
d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER <i>House Staff</i>				29b. LICENSE NUMBER AS2441614-11		29c. DATE SIGNED (Month, Day, Year) 5/13/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Sridhar. Atluri M.D., Harbor Hosp. Center, 3001 S. Hanover St. BALTIMORE MD 21225							
31. DATE FILED (Month, Day, Year) MAY 16 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 14789

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Geraldine Bogier</u>				2. DATE OF DEATH MONTH <u>May</u> DAY <u>13</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>04:00a.m.</u>	
4. SOCIAL SECURITY NUMBER <u>220-22-2121</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>66</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>MAR. 15, 1929</u>	
8. BIRTHPLACE (State or Foreign Country) <u>MARYLAND</u>				9a. FACILITY NAME (If not institution, give street and number) <u>CHURCH HOME HOSPITAL</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>BALTIMORE CITY</u>	
9c. COUNTY OF DEATH <u>N/A</u>				10a. STATE <u>MARYLAND</u>		10b. COUNTY <u>N/A</u>	
10c. CITY, TOWN OR LOCATION <u>BALTIMORE CITY</u>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>1626 N. WOLFE ST.</u>	
10f. ZIP CODE <u>21213</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>BLACK</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>7TH</u> College (14 or 5+) <u>N/A</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>NURSING</u>		16b. KIND OF BUSINESS/INDUSTRY <u>CAB HOME CARE COMPANY</u>	
17. FATHER'S NAME (First, Middle, Last) <u>WILLIAM BOGIER</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>LAURA CARTER</u>			
19a. INFORMANT'S NAME (Type/Print) <u>LORENA WATSON</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1626 N. WOLFE ST. BALTO, MD. 21213</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>MT. CALVARY CEM. 5-19-95</u>		20c. LOCATION — City or Town, State <u>ANNE ARUNDEL CO, MD</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Calvin B. Scruggs</u>				22. NAME AND ADDRESS OF FACILITY <u>CALVIN B. SCRUGGS FUNERAL HOME</u> <u>1412 E. PRESTON ST. BALTO, MD. 21213</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <u>Congestive Heart failure</u> DUE TO (OR AS A CONSEQUENCE OF):							
b. <u>Ischemic cardiomyopathy</u> DUE TO (OR AS A CONSEQUENCE OF):							
c. <u>Coronary artery disease</u> DUE TO (OR AS A CONSEQUENCE OF):							
d.							
Approximate Interval Between Onset and Death <u>4 days</u> <u>10 years</u> <u>15 years</u>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Diabetes mellitus, Chronic obstructive pulmonary disease, Pneumonia</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Khalid K. AL-TALIB M.D.</u>				29c. LICENSE NUMBER <u>D38882</u>		29d. DATE SIGNED (Month, Day, Year) <u>5/13/95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Khalid K. AL-TALIB, Church Home Hospital, Baltimore MD</u>							
31. DATE FILED (Month, Day, Year) <u>MAY 16 1995</u>				32. REGISTRAR'S SIGNATURE <u>Juli...</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Thelma G. Blake</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>11</b> , YEAR <b>1995</b>		3. TIME OF DEATH <b>10:30 AM</b>	
4. SOCIAL SECURITY NUMBER <b>215 34 8594</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 22, 1910</b>	
8. BIRTHPLACE (State or Foreign Country) <b>W. VA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1210 Washington Irvin Lane</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Middle River</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Middle River</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1210 Washington Irvin Lane</b>	
10f. ZIP CODE <b>21220</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary <input type="checkbox"/> Secondary (9-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Custodian</b>		16b. KIND OF BUSINESS/INDUSTRY <b>School</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William Hammonds</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Teal Roberts</b>			
19. INFORMANT'S NAME (Type/Print) <b>Dorma Lee Stewart</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1210 Washington Irvin Lane Balto. MD 21220</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, home, or other place) <b>Holly Hill Memorial Gard. 5/15/95</b>		20c. LOCATION — City or Town, State <b>Baltimore Co., MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Bruzdzinski Funeral Home PA 1407 Eastern Ave. Baltimore, MD 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Parkinsons Disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>Dementia</b> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> D.O.				29c. LICENSE NUMBER <b>H35593</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 12, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. John J. Loh 617 A Stemmers Run Road Balto., Md. 21221</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>George William Beck</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>12</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>1:23 p m</b>	
4. SOCIAL SECURITY NUMBER <b>184 12 4873</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 26, 1921</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Penna.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hospital Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Rossville</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Essex</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>336 Stillwater Road</b>	
10f. ZIP CODE <b>21221</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>World War 2</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Engineer</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Aero - Space</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Henry Beck</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Florence Mc Cormick</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Amelia L. Beck</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>336 Stillwater Road Essex, Maryland 21221</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE <b>Parkwood Cemetery May 15, 1995</b>			
20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			
22. NAME AND ADDRESS OF FACILITY <b>Bruzdinski Funeral Home P.A. 1407 Eastern Ave. Baltimore, Maryland 21221</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Pulmonary Fibrosis</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D35410</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/15/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Lisa Pfeiffer 6918 Ridge Rd. Baltimore MD 21237</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


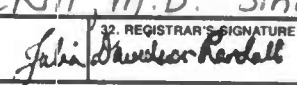
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14792

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES H. COHEN</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>10</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>2:25 P M</b>	
4. SOCIAL SECURITY NUMBER <b>219-01-3001</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>APR. 7, 1916</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>6803 WESTRIDGE ROAD</b>			
10f. ZIP CODE <b>21207</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SYSTEMS ANALYST</b>		16b. KIND OF BUSINESS/INDUSTRY <b>FEDERAL GOVERNMENT</b>			
17. FATHER'S NAME (First, Middle, Last) <b>NATHAN COHEN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNA BLECKER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. SYLVIA COHEN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6803 WESTRIDGE ROAD BALTIMORE, MD 21207</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or funeral home) <b>(ANGIE EMMAN) AITZ CHAIM 5-11-1995 BALTIMORE, MD</b>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. METASTATIC LUNG CANCER</b> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>2 years</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Connie McRill M.D. Resident</b>				29c. LICENSE NUMBER <b>AS2402321-CM9841</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 10, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Connie McRill, M.D. Sinai Hospital of Baltimore</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GREGORY ANTONIO CHAVEZ				2. DATE OF DEATH MONTH DAY YEAR MAY 14 1995		3. TIME OF DEATH 5:50 P.M.					
4. SOCIAL SECURITY NUMBER 219-66-9174		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 37 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 13, 1958		8. BIRTHPLACE (State or Foreign Country) BALTIMORE, MD			
9a. FACILITY NAME (If not institution, give street and number) 2000 BLK. LLEWELYN AVE				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY			9c. COUNTY OF DEATH n/a				
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				
10e. STREET AND NUMBER 3312 ELMLEY AVENUE				10f. ZIP CODE 21213		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: BLACK				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) G.E.D.		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER		16b. KIND OF BUSINESS/INDUSTRY VARIOUS TRADES							
17. FATHER'S NAME (First, Middle, Last) ISAIAH EDWARDS JR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIE M. GOMEZ							
19a. INFORMANT'S NAME (Type/Print) DINAH BOARDLEY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3312 ELMLEY AVENUE, BALTIMORE, MARYLAND 21213							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARBUTUS MEMORIAL PARK 5-18		20c. LOCATION — City or Town, State ARBUTUS, MARYLAND							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>See V. Holland</i>				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Ligature strangulation, suffocation and blunt force injuries of head.</i> b. <i>blunt force injuries of head.</i> c. <i></i> d. <i></i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 5-14-95		28b. TIME OF INJURY 1745 M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <i>subject strangled, suffocated and beaten</i>			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>Car on Roadway</i>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>2000 blk Llewellyn Ave Baltimore</i>									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) MAY 15, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>David R Fowler</i> 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) MAY 16 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Luke HAYES Carter</b>				2. DATE OF DEATH MONTH <b>May</b> , DAY <b>8</b> , YEAR <b>1995</b>		3. TIME OF DEATH <b>5:15 A</b> M	
4. SOCIAL SECURITY NUMBER <b>250-58-2081</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>60</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10-4-1934</b>	
8. BIRTHPLACE (State or Foreign Country) <b>FLORENCE, S.C.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Maryland General Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH				10a. STATE <b>MARYLAND</b>			
10b. COUNTY <b>CITY</b>				10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1027 CATHEDRAL STREET APT 11-L</b>			
10f. ZIP CODE <b>21201</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 8+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HARBOURS &amp; WALKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>UNKNOWN</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JULIUS N. CARTER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>VIOLA SKEETER CARTER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ADA SIMMONS CARTER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1027 CATHEDRAL STREET, APT 11-L BALTO, MD. 21201</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. ZION CEMETERY 5/12/97</b>		20c. LOCATION — City or Town, State <b>HOLLINS FERRY, RD.</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY <b>ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MD. 21217</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  a. <b>Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Chronic Renal Failure</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Hypertension</b> DUE TO (OR AS A CONSEQUENCE OF): d.  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER MD				29c. LICENSE NUMBER <b>89189</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 8, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Emmanuel Guerrero, M.D. c/o Maryland General Hospital</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14795

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Theodore Clark</i>				2. DATE OF DEATH MONTH <i>05</i> DAY <i>12</i> YEAR <i>95</i>		3. TIME OF DEATH <i>6:00 A.M.</i>	
4. SOCIAL SECURITY NUMBER <i>213-20-8233</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>69</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>July 18 1925</i>	
8. BIRTHPLACE (State or Foreign Country) <i>MARYLAND</i>				9a. FACILITY NAME (If not institution, give street and number) <i>BON SECOURS HOSPITAL</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE CITY</i>	
9c. COUNTY OF DEATH <i>N/A</i>				10a. STATE <i>MARYLAND</i>		10b. COUNTY <i>N/A</i>	
10c. CITY, TOWN OR LOCATION <i>BALTIMORE CITY</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>1701 Eutaw Place Apt. 407</i>	
10f. ZIP CODE <i>21217</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>UNKNOWN</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>LABOR</i>		16b. KIND OF BUSINESS/INDUSTRY <i>CONSTRUCTION</i>	
17. FATHER'S NAME (First, Middle, Last) <i>WILLIAM EDWARD CLARK</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>MARY E. GREENARD</i>			
19a. INFORMANT'S NAME (Type/Print) <i>JEANETTE C. GRIFFIN</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1701 Eutaw Place Apt 407, Baltimore, Maryland 21217</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Woodlawn Cemetery 5/16</i>		20c. LOCATION — City or Town, State <i>Woodlawn, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles Moore</i>				22. NAME AND ADDRESS OF FACILITY <i>WILLIAM C. BROWN COMMUNITY F/H 1206 W. North Avenue</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Respiratory failure</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>b. Renal failure</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c. Seizure disorder</i> DUE TO (OR AS A CONSEQUENCE OF): <i>d. Congestive heart failure</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dementia</i> <i>Decreased Hearing</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Greenish K. Tripuramani</i>			
29c. LICENSE NUMBER <i>D30661</i>				29d. DATE SIGNED (Month, Day, Year) <i>May 12<sup>th</sup> 1995</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>GREENISH K. TRIPURAMANI, Bon Secours Hospital, Baltimore, Md - 21223</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 16 1995</i>				32. REGISTRAR'S SIGNATURE <i>John William Randle</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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10-10-10

July 10 1930

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FANNIE CHADAKOWSKY</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>10</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>6 PM</b>	
4. SOCIAL SECURITY NUMBER <b>214-40-2662</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>NOV. 14, 1912</b>	
8. BIRTHPLACE (State or Foreign Country) <b>NEW YORK</b>		9a. FACILITY NAME (If not institution, give street and number) <b>3014 FALLSTAFF MANOR COURT, APT. E</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3014 FALLSTAFF MANOR CT, APT. E</b>				10f. ZIP CODE <b>21209</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>PRINCIPAL</b>		16b. KIND OF BUSINESS/INDUSTRY <b>EDUCATION</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ISAAC CHADAKOWSKY</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>GOLDIE WEPRINSKY</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. LISA GERBERG</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 VALLEY GLEN CT. REISTERSTOWN, MD 21136</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MOSES MONTEFIORE</b>		20c. DATE <b>5-12-1995</b>		20d. LOCATION — City or Town, State <b>BALTIMORE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		<b>Uterine Cancer</b> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D38972</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 12, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. HOWARD ABBAS 2411 W. BELVEDERE AVE. BALTIMORE, MD 21215</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95-2650-510  
DWG

95 14797

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WOODROW WILSON COLE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 07 95</b>		3. TIME OF DEATH <b>10:31P M</b>	
4. SOCIAL SECURITY NUMBER <b>217-05-5309</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 15, 1917</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Kentucky</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1931 WEST LOMBARD STREET</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>Md.</b>		10b. COUNTY <b>N/A</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1931 W. Lombard St.</b>	
10f. ZIP CODE <b>21223</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Bridge Tender</b>		16b. KIND OF BUSINESS/INDUSTRY <b>State of Maryland</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Lee Mat Cole</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Maggie Jane Redman</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Alice Marie Cole</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1931 W. Lombard St., Baltimore, Md. 21223</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Good Shepherd Cemetery 5/13</b>		20c. LOCATION — City or Town, State <b>Ellicott City, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY <b>Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Gunshot Wounds (2) to Chest</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d.</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>5/7/95</b>		28b. TIME OF INJURY <b>2224H</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>Subject shot</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>home</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>1931 West Lombard Street Baltimore, Maryland</b>			
29a. CERTIFIER <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Raymond D. Smith</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 08/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>THEODORE KING MD 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO  
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CHICAGO, ILL. 60637



95 14798

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM E. COOK SR.</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>14</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>11:05 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>215 03 9092</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 6, 1915</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Harbor Hospital Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>Anne Arundel</b>				10c. CITY, TOWN OR LOCATION <b>Baltimore</b>			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>498 Matthews Avenue</b>			
10f. ZIP CODE <b>21225</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>10th</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Stationary Engineer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>A.A. Co. Board of Education</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William E. Cook Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Eva Suit</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Marie B. Cook</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>498 Matthews Avenue Baltimore, Maryland 21225</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>		DATE <b>5/15</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Myasthenic Crisis</b> Due to (or as a consequence of): <b>b. Myasthenia Gravis</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. d. Approximate Interval Between Onset and Death <b>~ 4 days</b> <b>6 yrs.</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>MARY JUDYLINE J. MINGUITO M.D.</b>				29c. LICENSE NUMBER <b>AS2441614-22</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 14, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARY JUDYLINE J. MINGUITO 3001 SOUTH HANOVER ST. BMT, MD 21225</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

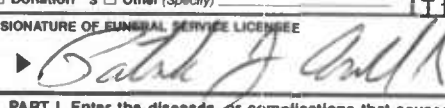
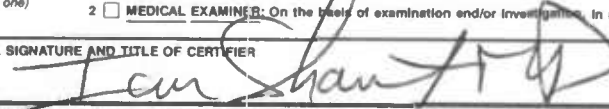
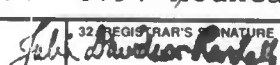
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14799

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Victoria Cerase</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 12 1995</b>		3. TIME OF DEATH <b>1:30 A M</b>	
4. SOCIAL SECURITY NUMBER <b>180-93-9677</b>		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug 25 1912</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Knollwood Manor Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Millersville</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Severna Park</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>49 Snellings Court</b>				10f. ZIP CODE <b>21146</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b></b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Sobolewski</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Julia Tesar</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Marie Zabiegalski</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>49 Snellings Ct., Severna Park, Md 21146</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Italian Independence Cem</b>		DATE <b>5-16-95</b>		20c. LOCATION — City or Town, State <b>Glen Lyon, Pa.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Hardesty Funeral Home, P.A., 12 Ridgely Ave., Annapolis, Md 21401</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Urinary Tract Infection</b>					Approximate Interval Between Onset and Death <b>10 days</b>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>Multi-Infarct Dementia</b>					<b>years</b>
		c. <b>Hypertension</b>					<b>years</b>
		d. <b></b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>None Known</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Dr. Ian Shantz</b>				29c. LICENSE NUMBER <b>D 36203</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 12, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Ian Shantz 4191 Mountain Road Pasadena MD 21122</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

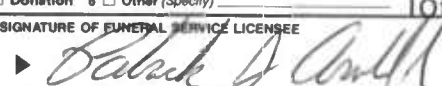
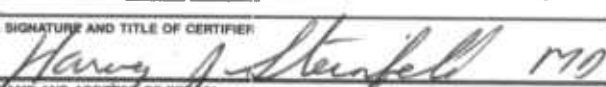
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14800

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Dora Elizabeth Parker Carter</b>				2. DATE OF DEATH MONTH DAY YEAR <b>5/14/95</b>		3. TIME OF DEATH <b>10:00a</b> M	
4. SOCIAL SECURITY NUMBER <b>138-03-8484</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs., last birthday) <b>93</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jun. 29, 1901</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1037 Franklin Manor Road</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Churchton</b>	
9c. COUNTY OF DEATH <b>Anne Arundel</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>	
10c. CITY, TOWN OR LOCATION <b>Churchton</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1037 Franklin Manor Road</b>	
10f. ZIP CODE <b>20733</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Sales</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Woolworth Co.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John J. Parker</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary E. Maddox</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Thelma Jameson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>139B Old Trappe Lane, MD 20609</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Our Lady of Sorrows</b>		OATE <b>5/18</b>		20c. LOCATION — City or Town, State <b>Owensville, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIAC ARREST.</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>205158</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/15/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>HARVEY J. STRAINFIELD, SHADYSIDE MD 20764</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Cooper, Vonneta</i> VONETTA ANN COOPER				2. DATE OF DEATH MONTH <i>5</i> DAY <i>13</i> YEAR <i>95</i>		3. TIME OF DEATH <i>5:45 PM</i> M	
4. SOCIAL SECURITY NUMBER 212-48-3403		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 48 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT. 29, 1946	
9a. FACILITY NAME (If not institution, give street and number) sinai HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH NONE	
10a. STATE MARYLAND		10b. COUNTY NONE		10c. CITY, TOWN OR LOCATION BALTIMORE CITY		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4406 BELLEVIEW AVE				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <i>XX</i>		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) N/A College (1-4 or 5+) 4 YEARS		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SCHOOL TEACHER		16b. KIND OF BUSINESS/INDUSTRY BALTIMORE CITY PUBLIC SCHOOLS			
17. FATHER'S NAME (First, Middle, Last) WARREN B. WEEMS, SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) ALEASE YORKMAN			
19a. INFORMANT'S NAME (Type/Print) MANUEL COOPER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4406 BELLEVIEW AVE. BALTO, MD. 21215			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VETERANS		DATE		20c. LOCATION — City or Town, State OWINGS MILLS, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin B. Scruggs</i>				22. NAME AND ADDRESS OF FACILITY CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Respiratory Arrest / Cardiac Arrest</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Acute Renal Failure</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>End Stage Metastatic Breast Cancer</i> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death <i>48 hours</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Thomas B. Fiaretti</i> #3014				29c. LICENSE NUMBER <i>D40836</i>		29d. DATE SIGNED (Month, Day, Year) <i>5/13/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Fiaretti, Thomas B.</i> THOMAS B. FIARETT SINAI HOSPITAL H							
31. DATE FILED (Month, Day, Year) MAY 16 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14802

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>MARION CRAWFORD</u>				2. DATE OF DEATH MONTH <u>MAY</u> DAY <u>09</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>4:10 PM</u>	
4. SOCIAL SECURITY NUMBER <u>218-44-5822</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>48</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>MAY 16, 1946</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>MERCY MEDICAL CENTER</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>BALTO., MD</u>		9c. COUNTY OF DEATH <u>N/A</u>	
10a. STATE <u>MARYLAND</u>				10b. COUNTY <u>N/A</u>		10c. CITY, TOWN OR LOCATION <u>BALTO. CITY</u>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <u>826 N. BOND ST.</u>				10f. ZIP CODE <u>21205</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>BLACK</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>9TH</u> College (1-4 or 5+) <u>N/A</u>		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>TEACHER'S AIDE</u>		16b. KIND OF BUSINESS/INDUSTRY <u>FIRST BAPTIST CHURCH SCHOOL</u>			
17. FATHER'S NAME (First, Middle, Last) <u>WILBERT MOORE</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>ANNA MOORE</u>			
19a. INFORMANT'S NAME (Type/Print) <u>ANNA MOORE</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>826 N. BOND ST. BALTO., MD. 21205</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>MT. ZION CEMETERY 5/15/95</u>		20c. LOCATION — City or Town, State <u>BALTO., MD.</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Calvin B. Scruggs Jr.</u>		22. NAME AND ADDRESS OF FACILITY <u>CALVIN B. SCRUGGS FUNERAL HOME</u> <u>1412 E. PRESTON ST. BALTO., MD. 21213</u>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>COAGULOPATHY</u>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <u>SEPSIS</u> b. <u>INTRAVENOUS DRUG ABUSE</u> c. <u>RENAL FAILURE, HEPATIC FAILURE</u> d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>RENAL FAILURE, HEPATIC FAILURE</u>							Approximate Interval Between Onset and Death <u>10 days</u> <u>10 days</u> <u>YEARS</u>
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE NOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Michael Reinhard</u>				29c. LICENSE NUMBER <u>PO 8179</u>		29d. DATE SIGNED (Month, Day, Year) <u>MAY 09 1995</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>MICHAEL REINHARD M.D. - MERCY MEDICAL CENTER BALTIMORE, MD</u>							
31. DATE FILED (Month, Day, Year) <u>MAY 16 1995</u>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14803

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Annie Lee COMER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 12, 1995</b>		3. TIME OF DEATH <b>10:47 a<sup>m</sup></b>	
4. SOCIAL SECURITY NUMBER <b>244-46-1443</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>Mar. 31, 1933</b>	
8. BIRTHPLACE (State or Foreign Country) <b>North Carolina</b>				9. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hospital</b>			
10. CITY, TOWN OR LOCATION OF DEATH <b>Rossville</b>				11. COUNTY OF DEATH <b>Baltimore County</b>			
12. STATE <b>Md.</b>		13. COUNTY <b>Baltimore</b>		14. CITY, TOWN OR LOCATION <b>Essex</b>		15. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
16. STREET AND NUMBER <b>674 Middlesex Road</b>				17. ZIP CODE <b>21221</b>		18. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
19. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		20. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		22. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
23. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+) <b>College</b>		24. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		25. KIND OF BUSINESS/INDUSTRY <b>own home</b>			
26. FATHER'S NAME (First, Middle, Last) <b>Pressley Reep</b>				27. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Cordie Speagle</b>			
28. INFORMANT'S NAME (Type/Print) <b>Lloyd C. Comer</b>				29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>149 Riverthorn Road Baltimore Md. 21220</b>			
30. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		31. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holly Hill Cemetery 5/16/95</b>		32. DATE <b>5/16/95</b>		33. LOCATION — City or Town, State <b>Baltimore Md.</b>	
34. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>R. Terry Connelly</b>				35. NAME AND ADDRESS OF FACILITY <b>Connelly Funeral Home of Essex 300 Mace Ave Baltimore Md. 21221</b>			
36. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia And Multi-system organ Failure</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Chronic Obstructive Pulmonary Disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Renal Vein Thrombosis, Left, With Hemorrhagic infarction</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Pulmonary Emboli, Right Lower Lobe, Left Upper Lobe</b>							
37. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Illeus</b> <b>Renal Failure</b> <b>Cerebral Hemorrhage</b>							
38. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		39. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
40. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		41. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
42. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		43. DATE OF INJURY (Month, Day, Year)		44. TIME OF INJURY <b>M</b>		45. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
46. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				47. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
48. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
49. SIGNATURE AND TITLE OF CERTIFIER <b>B. Pharoan</b>				50. LICENSE NUMBER <b>D19637</b>		51. DATE SIGNED (Month, Day, Year) <b>5/15/95</b>	
52. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>B. PHAROAN, M.D. 4744A RIDGE RD BALTO MD 21236</b>							
53. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>		54. REGISTRAR'S SIGNATURE <b>J. J. [Signature]</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Pulmonary Emboli, Right Lower Lobe, Left Upper Lobe  
Renal Vein Thrombosis, Left, With Hemorrhagic Infarction  
Chronic Obstructive Pulmonary Disease

Pneumonia And MALT System Organ Failure.

300 Mace Ave. Baltimore Md. 21221  
Connelly Funeral Home of Essex

Holly Hill Cemetery 5/16/95 Baltimore Md.

149 Riverthorn Road Baltimore Md. 21220  
Cordie Speddie

Lloyd C. Comer  
Pressley Reep

x

*R. T. Connelly*

95 14804

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROBERT LEWIS DENHARDT, SR.</b>				2. DATE OF DEATH <b>MAY 6th 1995</b>		3. TIME OF DEATH <b>8:32 PM</b>	
4. SOCIAL SECURITY NUMBER <b>213-32-1683</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>59</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 27, 1935</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>NORTH ARUNDEL HOSPITAL ASSOCIATION</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>GLEN BURNIE</b>		9c. COUNTY OF DEATH <b>Maryland</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Pasadena</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>371 Dutchship Court</b>				10f. ZIP CODE <b>21122</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Korea</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Shipfitter</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Dept. of Transportation U.S. Coast Guard</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Henry Phillip Denhardt</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Inez Lee Sullivan</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Elizabeth M. Denhardt</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>371 Dutchship Ct. Pasadena, Md. 21122</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory Inc. May 10, 1995 Catonsville, Md.</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert J. [Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>McCully Funeral Home 3204 Mountain Rd. Pasadena, Md. 21122</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>brainstem stroke</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>cerebrovascular disease</b> <b>hydrocephalus, pulmonary emboli</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>hydrocephalus, pulmonary emboli</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>DS 387</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/11/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JAMES J. BENJAMIN, M.D./479 JUMPERS HOLE ROAD, 3RD FLOOR/SEVERNA PARK, MARYLAND</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FRANCIS JOHN EICHOLTZ</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>12</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>9:40 A.</b> M	
4. SOCIAL SECURITY NUMBER <b>220-14-2504</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 19, 1925</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Stella Maris Hospice</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Bal</b> N/A		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2900 Gibbons Ave.</b>				10f. ZIP CODE <b>21214</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW-II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>7</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Jeweler</b>		16b. KIND OF BUSINESS/INDUSTRY <b>The Clock Shop</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Arnold J. Eicholtz</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Clarke</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Mary D. Eicholtz</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2900 Gibbons Ave., Baltimore, Md. 21214</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem. Gdns. 5/15/95 Timonium, Md.</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Ruck Towson Funeral Home, Inc. 1050 York Rd Towson, Md 21204</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ADENOCARCINOMA OF LUNG</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death <b>6 mos.</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>D25643</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/12/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>THOMAS</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>12</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>11:10 A.M.</b>			
4. SOCIAL SECURITY NUMBER <b>220-07-7309</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept 12, 1912</b>		8. BIRTHPLACE (State or Foreign Country) <b>Md</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>929 VALLEY STREET</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH <b>N/A</b>			
10a. STATE <b>Md</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>929 Valley Street</b>				10f. ZIP CODE <b>21202</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U S A</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>6th grade</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>		16. KIND OF BUSINESS/INDUSTRY <b>Bethlehem Steel</b>							
17. FATHER'S NAME (First, Middle, Last) <b>William Elsey</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Addie Giles</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Sarah Watts</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1533 Ingleside Avenue Baltimore, Md 21207</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest Vet</b>		DATE <b>51895</b>		20c. LOCATION — City or Town, State <b>Owings Mills, Md</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jerome A. Thompson</i>				22. NAME AND ADDRESS OF FACILITY <b>March F/H West 4300 Wabash Avenue Avenue Balto, Md 21215</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Atherosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Asthma</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jerome A. Thompson</i>						29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 13, 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>111 Penn Street, Baltimore, Maryland 21201</b>											
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1. The first part of the report is a general introduction to the subject of the study.

2. The second part of the report is a detailed description of the methods used in the study.

3. The third part of the report is a discussion of the results of the study.

95 14808

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Bashoff Faye</i>				2. DATE OF DEATH MONTH <i>May</i> DAY <i>9</i> YEAR <i>1995</i>				3. TIME OF DEATH <i>12:40 P</i>	
4. SOCIAL SECURITY NUMBER <i>212-52-9530</i>		5. SEX <i>1</i> <input type="checkbox"/> M <i>2</i> <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>86</i> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____	
7. DATE OF BIRTH (Month, Day, Year) <i>JAN 21, 1909</i>				8. BIRTHPLACE (State or Foreign Country) <i>MARYLAND</i>					
9a. FACILITY NAME (If not institution, give street and number) <i>JOSEPH RICHEY HOSPICE</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i>				9c. COUNTY OF DEATH <i>N/A</i>	
10a. STATE <i>MARYLAND</i>		10b. COUNTY <i>BALTIMORE</i>		10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>				10d. INSIDE CITY LIMITS? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>130 SLADE AVE, APT. 608</i>				10f. ZIP CODE <i>21208</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS <i>1</i> <input type="checkbox"/> Never Married <i>2</i> <input checked="" type="checkbox"/> Married <i>3</i> <input type="checkbox"/> Widowed <i>4</i> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HOUSEWIFE</i>				16b. KIND OF BUSINESS/INDUSTRY <i>AT HOME</i>			
17. FATHER'S NAME (First, Middle, Last) <i>BENJAMIN GINSBERG</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>ELIZABETH GREENBERG</i>					
19a. INFORMANT'S NAME (Type/Print) <i>MR. NORMAN GINSBERG</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>355 KINGSBURY WAY WESTMINSTER, MD 21157</i>					
20a. METHOD OF DISPOSITION <i>1</i> <input checked="" type="checkbox"/> Burial <i>2</i> <input type="checkbox"/> Cremation <i>3</i> <input type="checkbox"/> Removal from State <i>4</i> <input type="checkbox"/> Donation <i>6</i> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>HEBREW YOUNG MEN</i>		DATE <i>5-11-1995</i>		20c. LOCATION — City or Town, State <i>BALTIMORE, MD</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSER <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</i>					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Respiratory Arrest</i> Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Carcinoma Esophageal</i>								Approximate Interval Between Onset and Death <i>Minutes</i> <i>4 mos</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <i>1</i> <input type="checkbox"/> Inpatient <i>2</i> <input type="checkbox"/> ER/Outpatient <i>3</i> <input type="checkbox"/> DOA OTHER: <i>4</i> <input type="checkbox"/> Nursing Home <i>5</i> <input type="checkbox"/> Residence <i>6</i> <input checked="" type="checkbox"/> Other (Specify) <i>Hospice</i>							
27. MANNER OF DEATH <i>1</i> <input checked="" type="checkbox"/> Natural <i>5</i> <input type="checkbox"/> Pending Investigation <i>2</i> <input type="checkbox"/> Accident <i>6</i> <input type="checkbox"/> Could not be determined <i>3</i> <input type="checkbox"/> Suicide <i>4</i> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <i>1</i> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>2</i> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER <i>208900</i>		29d. DATE SIGNED (Month, Day, Year) <i>5/10/95</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>ROBERT C. Irwin 828 N. Cuthaw St. Baltimore, MD 21201</i>									
31. DATE FILED (Month, Day, Year) <i>MAY 16 1995</i>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95-2779-510

blh

ITEMS: 23 PART I, II, 27, PER MEO FILM G-723 5/31/95 t.t

95 14809

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Levin E Fooks</u>				2. DATE OF DEATH MONTH DAY YEAR <u>May 13 1995</u>		3. TIME OF DEATH M <u>1425</u>	
4. SOCIAL SECURITY NUMBER <u>215-36-1407</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>54</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>11/01/1940</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Church Home Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>		9c. COUNTY OF DEATH <u>N/A</u>	
10a. STATE <u>Md.</u>				10b. COUNTY <u>N/A</u>		10c. CITY, TOWN OR LOCATION <u>Baltimore</u>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <u>227 S. Herring Ct.</u>			
10f. ZIP CODE <u>21231</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>11</u> College (1-4 or 5+) <u>0</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Dock Worker</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Manufacturer</u>			
17. FATHER'S NAME (First, Middle, Last) <u>James Henry Fooks</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Lillian Jones</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Alice Fooks</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>227 S. Herring Ct. Baltimore, Md. 21231</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Mt. Carmel Cemetery</u> <u>5-18</u>		20c. LOCATION — City or Town, State <u>Baltimore City</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Kathleen Weber</u>				22. NAME AND ADDRESS OF FACILITY <u>David J. Weber Funeral HOME</u> <u>401 S. Chester Street BALTO. Md. 21231</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>CARDIAC ARRHYTHMIA, ATHEROSCLEROTIC CARDIOVASCULAR DISEASE AND CARDIOMEGALY</u> Approximate Interval Between Onset and Death							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>DIABETES MELLITUS</u>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Demetrius J. Chute MD</u>				29c. LICENSE NUMBER <u>O.C.M.E.</u>		29d. DATE SIGNED (Month, Day, Year) <u>May 14 1995</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>111 Penn Street, Baltimore, Maryland 21201</u>							
31. DATE FILED (Month, Day, Year) <u>MAY 16 1995</u>		32. REGISTRAR'S SIGNATURE <u>John Andrew Kerkell</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14810

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Elsie Fuller</i>				2. DATE OF DEATH MONTH DAY YEAR <i>MAY 03 1995</i>		3. TIME OF DEATH <i>08 44 AM</i>	
4. SOCIAL SECURITY NUMBER <i>212-26-4601</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>88</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>5/21/1906</i>	
8a. FACILITY NAME (If not institution, give street and number) <i>Mercy Medical Center</i>				8b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>		8c. COUNTY OF DEATH <i>Baltimore</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>MARYLAND</i>		10b. COUNTY <i>CITY</i>		10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>2517 W. MOSHER STREET</i>				10f. ZIP CODE <i>21216</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify		14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>02</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>BEAUTICIAN</i>		16b. KIND OF BUSINESS/INDUSTRY <i>HAIR &amp; BEAUTY SALONS</i>			
17. FATHER'S NAME (First, Middle, Last) <i>JOHN WOOLFORD</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>HELEN WOOLFORD</i>			
19a. INFORMANT'S NAME (Type/Print) <i>GWENDOLYN WOOLFORD</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2517 W. MOSHER ST. BALTIMORE, MARYLAND 21216</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>ARBUTUS MEMORIAL PARK 5/8/95</i>		20c. LOCATION — City or Town, State <i>ARBUTUS, MARYLAND</i>		22. NAME AND ADDRESS OF FACILITY <i>ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MD. 21217</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MD. 21217</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Renal Failure</i> DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death <i>2 weeks</i>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. <i>Bladder Cancer</i> DUE TO (OR AS A CONSEQUENCE OF):				<i>5 years</i>	
		c. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Anemia, blindness</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>P08182</i>		29d. DATE SIGNED (Month, Day, Year) <i>MAY 3, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>SCOTT E L9 Borwit 301 ST Pul Pl Baltimore, Maryland 21202</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 16 1995</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 14811

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>PATRICIA LEE FRAILER</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>11</b> , YEAR <b>1995</b>		3. TIME OF DEATH <b>10:10 P. M.</b>	
4. SOCIAL SECURITY NUMBER <b>214-44-2351</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>50</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>08-25-1944</b>	
8. FACILITY NAME (If not institution, give street and number) <b>7920 SEVERN HILLS WAY</b>				9. CITY, TOWN OR LOCATION OF DEATH <b>SEVERN</b>		10. COUNTY OF DEATH <b>MARYLAND</b>	
11. RESIDENCE OF DECEDENT 10a. STATE <b>MARYLAND</b> 10b. COUNTY <b>ANNE ARUNDEL</b>				10c. CITY, TOWN OR LOCATION <b>SEVERN</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7920 SEVERN HILLS WAY</b>				10f. ZIP CODE <b>21144</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SECRETARY</b>		16b. KIND OF BUSINESS/INDUSTRY <b>FEDERAL GOVERNMENT</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOHN FRANCIS SHARP, JR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EVELYN WOODSIDE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>WILLIAM JOHN FRAILER, JR.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7920 SEVERN HILLS WAY, SEVERN, MARYLAND 21144</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MARYLAND VETERANS CEMETERY</b> DATE <b>5/15/1995</b>		20c. LOCATION — City or Town, State <b>CROWNSVILLE, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael C. Saffian</i>				22. NAME AND ADDRESS OF FACILITY <b>SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 21061</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Breast Cancer</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John H. Fetting, M.D.</i>				29c. LICENSE NUMBER <b>518320</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/12/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John H. Fetting, M.D. Johns Hopkins Oncology Center BALTO MD 21287</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <i>John H. Fetting</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO

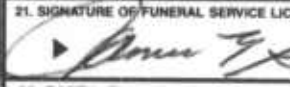


DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

**IMPORTANT:** If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

1. DECEDENT'S NAME (First, Middle, Last) <b>ELVA FITZE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 14, 1995</b>		3. TIME OF DEATH <b>2:05 A.</b>	
4. SOCIAL SECURITY NUMBER <b>219-16-4709</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 27, 1926</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Stella Maris Hospice</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		8c. COUNTY OF DEATH <b>Baltimore</b>	
9. RESIDENCE OF DECEDENT				10. CITY, TOWN OR LOCATION		11. INSIDE CITY LIMITS?	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Middle River</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2127 Graythorn Road</b>				10f. ZIP CODE <b>21220</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12) <b>11</b>		College (1-4 or 5+)		Housewife		Home	
17. FATHER'S NAME (First, Middle, Last) <b>Harry P. Clare</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rebekah Rees</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Judy Ramsey</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2812 Cross Country Ct. Fallston, MD. 21047</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of Facility) <b>Gardens of Faith Cemetery</b>		20c. LOCATION — City or Town, State <b>Baltimore County</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Bruzdziński Funeral Home P.A. 1407 Old Eastern Ave. Balt. MD. 21221</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SQUAMOUS CELL LUNG CANCER</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>						Approximate Interval Between Onset and Death <b>2 mos.</b>	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>DR. KENDALL FAULKNER</b>				29c. LICENSE NUMBER <b>D25643</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/15/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>		32. REGISTRAR'S SIGNATURE 					



95 14813

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Myrtle A. Goss</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 15 1995</b>		3. TIME OF DEATH <b>2:10 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>235 34 7328</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 11, 1907</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Maryland Manor of Glen Burnie Inc.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Marley</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>2825 Pennsylvania Avenue</b>			
10f. ZIP CODE <b>21227</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housekeeper</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Church</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Lloyd W. Tenney</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Birdie Snyder</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Isabell Stull</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2825 Pennsylvania Avenue Baltimore, Maryland 21227</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		20c. LOCATION — City or Town, State <b>5/18 Baltimore, Maryland</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>George J. Gonce</b>	
22. NAME AND ADDRESS OF FACILITY <b>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebrovascular Accident</b> <b>II. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>Hypothyroid</b> <b>III. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>Pernicious Anemia</b> <b>IV. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>				Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Harjit Singh, M.D. (Attending Physician)</b>		29c. LICENSE NUMBER <b>D14160</b>		29d. DATE SIGNED (Month, Day, Year) <b>05-15-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>		REGISTRAR'S SIGNATURE <b>J. A. Anderson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14814

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Audrey M. Giddings</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>8</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>6:45 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>217-34-1993</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>58</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCTOBER 17, 1936</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>LAUREL REGIONAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>LAUREL</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGE</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>HOWARD</b>		10c. CITY, TOWN OR LOCATION <b>LAUREL</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>9442 OLD SCAGGSVILLE ROAD</b>				10f. ZIP CODE <b>20723</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CLERK</b>		16b. KIND OF BUSINESS/INDUSTRY <b>RETAIL</b>	
17. FATHER'S NAME (First, Middle, Last) <b>JOHN F. DOLAN</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LAURA E. SIRLES</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CHARLES R. GIDDINGS, SR.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9442 OLD SCAGGSVILLE ROAD, LAUREL, MARYLAND 20723</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>EMMANUEL UNITED METH CH. CEM. 5/12</b>		20c. LOCATION — City or Town, State <b>LAUREL, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Extensive intradbbdominal hemorrhage</b> DUE TO (OR AS A CONSEQUENCE OF): <b>drab Aortic aneurysm</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Severe Arterio sclerotic vascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE NOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>William A. Warren</b>				29c. LICENSE NUMBER <b>D13916</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/8/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>William A. Warren 321 Prince George St. Laurel Md 20707</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HARVEY <del>DON</del> DON GRIFFIN				2. DATE OF DEATH MONTH DAY YEAR MAY 10 95		3. TIME OF DEATH 1:30 P.M.	
4. SOCIAL SECURITY NUMBER 458-60-7441		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-07-1940	
8. BIRTHPLACE (State or Foreign Country) TEXAS				9a. FACILITY NAME (If not institution, give street and number) 8 E. BEND COURT APT A		9b. CITY, TOWN OR LOCATION OF DEATH WOODLAWN	
9c. COUNTY OF DEATH BALTIMORE				10a. STATE MARYLAND		10b. COUNTY BALTIMORE	
10c. CITY, TOWN OR LOCATION WOODLAWN				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 8 E. BEND COURT, APARTMENT A	
10f. ZIP CODE 21244				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE YEAR OR DATES VIET NAM				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COMMUNICATIONS		16b. KIND OF BUSINESS/INDUSTRY U.S. DEPARTMENT OF STATES	
17. FATHER'S NAME (First, Middle, Last) WILLIAM HARVEY GRIFFIN				18. MOTHER'S NAME (First, Middle, Maiden Surname) IDAS LEE GLENN			
19a. INFORMANT'S NAME (Type/Print) LETICIA GRIFFIN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7639 E. ARBORY COURT, LAUREL, MARYLAND 20707			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HILLTOP SERVICES		20c. LOCATION — City or Town, State TOWSON, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 21061			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypertensive Atherosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic alcoholism							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO partial				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) MAY 11, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DENNIS J. CHUTE, M.D. 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) MAY 16 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DIERRA N. GILMORE				2. DATE OF DEATH MAY 12, 1995		3. TIME OF DEATH 10:49 AM	
4. SOCIAL SECURITY NUMBER 214-43-5357		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. 06 DAYS 00 HRS. 00 MIN.		7. DATE OF BIRTH (Month, Day, Year) 11-09-94	
8a. FACILITY NAME (If not institution, give street and number) NORTHWEST HOSPITAL CENTER				8b. CITY, TOWN OR LOCATION OF DEATH RANDALLSTOWN		8c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8341 CHURCH LANE APT 101				10f. ZIP CODE 21244		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A		16b. KIND OF BUSINESS/INDUSTRY N/A			
17. FATHER'S NAME (First, Middle, Last) ANTHONY GILMORE				18. MOTHER'S NAME (First, Middle, Maiden Surname) YOLANDA ELLISON			
19a. INFORMANT'S NAME (Type/Print) YOLANDA ELLISON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8341 CHURCH LANE APT 101 BALTO. MD 21244			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY 05-16-95		20c. LOCATION — City or Town, State LANSDOWNE, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY ALBERT P. WYLIE F/H PA 638 N. GILMOR STREET 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASPHYXIA DUE TO (OR AS A CONSEQUENCE OF): b. OVERLAYING DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 5-12-95		28b. TIME OF INJURY A M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED SUBJECT WAS ACCIDENTALLY LAYED ON		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8341 CHURCH LANE BALTIMORE CO., MD.	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) MAY 13, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOYLE JR. 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) MAY 16 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text at the bottom of the page, possibly a signature or date.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Gilbert William Heiland</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 7, 1995</b>		3. TIME OF DEATH <b>4:50 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>219-22-5365</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 3, 1926</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Atlantic General Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Berlin</b>	
9c. COUNTY OF DEATH <b>Worchester Co.</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Worchester</b>	
10c. CITY, TOWN OR LOCATION <b>Ocean City</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>617 Gulf Stream Dr.</b>	
10f. ZIP CODE <b>21842</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES <b>WW II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>1</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Journey Pressman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Alco Gravure</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Emil Heiland</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Teresa Jacob</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Marie Heiland</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>617 Gulf Stream Dr. Ocean City, Md. 21842</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Crownsville Vet. Cem. May 11, 1995 Crownsville, Md.</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Theresa J. ...</i>				22. NAME AND ADDRESS OF FACILITY <b>McCully Funeral Home 3204 Mountain Rd. Pasadena, Md. 21122</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>cerebral vascular accident</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>4/30/95</b>		28b. TIME OF INJURY <b>2:00 PM</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>home</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert Durkin</i>				29c. LICENSE NUMBER <b>H44283</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/7/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Robert Durkin 9733 Hops Hill way Drive Berlin MD</b>							
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE <b>MAY 16 1995 John Davidson Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14818

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Charles H. Henson</u>				2. DATE OF DEATH MONTH <u>5</u> DAY <u>7</u> YEAR <u>95</u>		3. TIME OF DEATH <u>10:00 a.m.</u>	
4. SOCIAL SECURITY NUMBER <u>212-14-2104</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>79</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>May 28, 1915</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>833 W. Pratt St.</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>		9c. COUNTY OF DEATH <u>NA</u>	
10a. STATE <u>Md</u>				10b. COUNTY <u>NA</u>		10c. CITY, TOWN OR LOCATION <u>Baltimore</u>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <u>833 W. Pratt St</u>			
10f. ZIP CODE <u>21201</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6th grade</u> College (1-4 or 5+) <u>MA</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Laborer</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Bethlehem Steel</u>			
17. FATHER'S NAME (First, Middle, Last) <u>William H. Henson</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Rose Johnson</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Gwendolyn Gray</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>6012 Amberwood Rd Apt B2 Baltimore, Md 21206</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Baltimore National Cem</u> <u>5/12/95</u>		20c. LOCATION — City or Town, State <u>Baltimore, Md</u>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Sala March</u>	
22. NAME AND ADDRESS OF FACILITY <u>March F.H. West</u> <u>4300 Wabash Ave Baltimore, Md 21215</u>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>Respiratory Arrest due to</u>				Approximate Interval Between Onset and Death <u>Unknown</u>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <u>Adenocarcinoma of Lung</u>				3 months	
		c. <u>Chronic Obstructive Pulmonary Disease</u>					
		d. <u>Tobacco Abuse</u>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Coronary Artery Disease</u> <u>S/P Coronary Artery Bypass x4</u>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <u>none</u>		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <u>none</u>		28e. DESCRIBE HOW INJURY OCCURRED <u>None</u>			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Nicholas M. Cardiges, MD</u>				29c. LICENSE NUMBER <u>P-05637</u>		29d. DATE SIGNED (Month, Day, Year) <u>5/10/95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 21) (Type, Print) <u>Nicholas M. Cardiges, MD</u> <u>Baltimore VA</u> <u>10 N. Greene St., Baltimore, MD 21201</u>							
31. DATE FILED (Month, Day, Year) <u>MAY 16 1995</u>		32. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14819

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mildred Mae Horner				2. DATE OF DEATH MONTH DAY YEAR MAY 13 1995		3. TIME OF DEATH 6:30 A M	
4. SOCIAL SECURITY NUMBER 214-34-2620		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUG 09, 1908	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) Meridian Cromwell Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Glen Arm				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 5323 Glen Arm Road	
10f. ZIP CODE 21057		10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary				16b. KIND OF BUSINESS/INDUSTRY Private School		17. FATHER'S NAME (First, Middle, Last) Edward Hummel	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Landis				19a. INFORMANT'S NAME (Type/Print) Jack F. Horner		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 North High Mount Joy, PA 17552	
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 05/15/95		20c. LOCATION — City or Town, State Baltimore, MD		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn F. McDonald	
22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Arteriosclerotic coronary artery disease</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.		Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Dementia</u>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Marion Kowaleski M.D.				29c. LICENSE NUMBER B21022		29d. DATE SIGNED (Month, Day, Year) May 15, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Marion Kowaleski, M.D. 8604 Harford Rd. Baltimore, MD 21234							
31. DATE FILED (Month, Day, Year) MAY 16 1995				32. REGISTRAR'S SIGNATURE John Davidson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14820

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>Robert William Hunter</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 14, 1995</b>		3. TIME OF DEATH <b>9:50 a m</b>	
4. SOCIAL SECURITY NUMBER <b>236-56-5040</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>59</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 03, 1935</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>785 Lancers Trail</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Crownsville</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Crownsville</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>785 Lancers Trail</b>				10f. ZIP CODE <b>21032</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1954-1962</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Computer Systems Analyst</b>		16b. KIND OF BUSINESS/INDUSTRY <b>National Security Agency</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Van Hunter</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Asia Odessa Bradley</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Margaret Evelyn Hunter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>785 Lancers Trail Crownsville, MD 21032</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 05/15/95</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Dawn F. McDonald</b>				22. NAME AND ADDRESS OF FACILITY <b>Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>ANAPLASTIC OLIGODENDROGLIOMA</b> DUE TO (OR AS A CONSEQUENCE OF):					
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Stuart Grossman M.D.</b>				29c. LICENSE NUMBER <b>023683</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 15, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Stuart Grossman, M.D. Johns Hopkins Oncology Center 600 N. Wolfe St. Balt. MD 21287</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>							

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEM: 1. PER F.H. FILM G-723 5/16/95 t.t

95 14821

1 - FOR  
STATE  
REGISTRAR

20b.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>David Hartley</b> DAVID A. HARTLEY				2. DATE OF DEATH MONTH <b>5</b> DAY <b>11</b> YEAR <b>95</b>		3. TIME OF DEATH <b>11:15 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>214 80 7922</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>34</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 26, 61</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>University Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1514 Cypress Street</b>			
10f. ZIP CODE <b>21226</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Construction Worker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Building / Construction</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Gerald Hartley</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elsie Muse</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Elsie Green</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1514 Cypress Street Baltimore, Maryland 21225</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>		20b. PLACE AND DATE OF DISPOSITION (Name of place and other place) <b>WOODLAWN Cemetery</b>		20c. LOCATION — City or Town, State <b>5/15 Baltimore, Maryland</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Richard E. Dine</b>				22. NAME AND ADDRESS OF FACILITY <b>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Anaplastic Astrocytoma</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Intractable Epilepsy</b> Approximate Interval Between Onset and Death <b>Months</b> <b>Years</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST d. _____ DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>M. Chehrensma</b>				29c. LICENSE NUMBER <b>P08545</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/11/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>M. Chehrensma Univ. of MD. Neurology Dept.</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Shuler-Rodell</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95-2685-510

B.K.S

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-723 5/22/95 t.t

95 14822

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MICHAEL HINES</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 8, 1995</b>		3. TIME OF DEATH <b>1857 P M</b>	
4. SOCIAL SECURITY NUMBER <b>212-78-6260</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>39</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>December 20, 1955</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1803 WICKS AVENUE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>1803 WICKS AVENUE</b>				10f. ZIP CODE <b>21230</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Deputy Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Courts</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Hines</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bernice Hines</b>			
19a. INFORMANT'S NAME (Type/Print) <b>GLORIA H. HINES</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1803 WICKS AVENUE BALTIMORE, MARYLAND 21230</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>McADAMS RIDGE Cemetery 5/12</b>		20c. LOCATION — City or Town, State <b>DORSEY, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>AMBROSIO FUNERAL HOME OF LANSDOWNE 2719 HAMMONDS FERRY RD. BALTO. MD. 21227</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		ii. <b>NARCOTIC INTOXICATION</b> DUE TO (OR AS A CONSEQUENCE OF): ia. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence 5 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input checked="" type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>FOUND 5-8-95</b>		28b. TIME OF INJURY <b>6:30 PM</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT INGESTED DRUGS</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>FOUND AT HOME</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>1803 WICKS AVE BALTIMORE, MD.</b>	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>O.C.M.E</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 9, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIE GOWEN 111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14823

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Gene Ball Hudson</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>11</b> , YEAR <b>1995</b>		3. TIME OF DEATH <b>11:05 p m</b>	
4. SOCIAL SECURITY NUMBER <b>412-36-9538</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 21, 1925</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>329 Essex Ave.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Essex</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Essex</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>329 Essex Ave.</b>				10f. ZIP CODE <b>21221</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>12th</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Pickler-Welder</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Beth Steel</b>	
17. FATHER'S NAME (First, Middle, Last) <b>James Leo Hudson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Jennie Ball</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Rosalie Hudson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>329 Essex Ave. Baltimore Md. 21221</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holly Hill Cemetery 5/16/95</b>		20c. LOCATION — City or Town, State <b>Baltimore Md.</b>		20d. DATE <b>5/16/95</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. Terry Connelly</i>				22. NAME AND ADDRESS OF FACILITY <b>Connelly Funeral Home of Essex 300 Maco Ave. Baltimore Md. 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Carcinomatosis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Squamous Cell Carcinoma of Lung</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>emphysema, asbestosis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jeffery M. Pergament</i>				29c. LICENSE NUMBER <b>D18642</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/12/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Jeffery M. Pergament, M.D. 9518-B Philadelphia Road Baltimore, Maryland 21237</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14824

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ellen Barbara HOFFMAN				2. DATE OF DEATH MONTH DAY YEAR May 13, 1995		3. TIME OF DEATH 10:05 P M	
4. SOCIAL SECURITY NUMBER 217-09-3476		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 18, 1916	
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rossville		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Essex		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 931 Barron Ave.				10f. ZIP CODE 21221		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY ownhome			
17. FATHER'S NAME (First, Middle, Last) Benjamin Roberts				18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Walter			
19a. INFORMANT'S NAME (Type/Print) Ralph A. Bien				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 931 Barron Ave. Baltimore Md. 21221			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 5/16/95		20c. LOCATION — City or Town, State Baltimore Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. Terry Connelly</i>				22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 1 hour
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>A. Youssri MD</i>				29c. LICENSE NUMBER D 46263		29d. DATE SIGNED (Month, Day, Year) 5/13/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr Ayman Youssri MD 9000 Franklin Square Drive Baltimore Maryland 21237							
31. DATE FILED (Month, Day, Year) MAY 16 1995				32. REGISTRAR'S SIGNATURE <i>John M. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14825

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jessie M. Hatfield				2. DATE OF DEATH MONTH DAY YEAR May 14, 1995		3. TIME OF DEATH estimate 9:00 A. M.	
4. SOCIAL SECURITY NUMBER 579-01-4490		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 11, 1911	
9a. FACILITY NAME (If not institution, give street and number) 634 Crucible Ct.				9b. CITY, TOWN OR LOCATION OF DEATH Millersville		8. BIRTHPLACE (State or Foreign Country) Washington D.C.	
10a. STATE Maryland				10b. COUNTY Anne Arundel		9c. COUNTY OF DEATH Anne Arundel	
10c. CITY, TOWN OR LOCATION Millersville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 634 Crucible Ct.				10f. ZIP CODE 21108		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 yrs. College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Eugene Thayer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret O'Conner			
19a. INFORMANT'S NAME (Type/Print) Barbara J. Curtis				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 634 Crucible Ct. Millersville, MD 21108			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory May 15, 1995		20c. LOCATION — City or Town, State Catonsville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Cori L. Ebaugh				22. NAME AND ADDRESS OF FACILITY Kirkley-Ruddick Funeral Home 421 Crain Hwy. S.E. Glen Burnie, MD 21061			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIAC INSUFFICIENCY DUE TO (OR AS A CONSEQUENCE OF): ASCVD Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER William P. Jones, MD Deputy				29c. LICENSE NUMBER D06054		29d. DATE SIGNED (Month, Day, Year) 5/15/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William P. Jones, MD 695 America Ct. 21035							
31. DATE FILED (Month, Day, Year) MAY 16 1995				32. REGISTRAR'S SIGNATURE John A. [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14826

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HARRIS, ANNIE MARIE GERWIG HARRIS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>05 10 95</b>		3. TIME OF DEATH <b>5:30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>219-22-6064</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>97</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>06-28-1897</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>JOHNS HOPKINS BAYVIEW MED.CEN.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>123 WEST 29th. STREET</b>				10f. ZIP CODE <b>21218</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10 YEARS</b> College (1-4 or 5+) <b>CLERK</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CLERK</b>		16b. KIND OF BUSINESS/INDUSTRY <b>OFFICE WORKER</b>			
17. FATHER'S NAME (First, Middle, Last) <b>J. THOMAS HARRIS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARGARET (UNK.)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LAWRENCE T. HARRIS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7859 LOCKWOOD ROAD, BALTIMORE, MD., 21222</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GREEN MOUNT CREMATORY 5-12</b>		20c. LOCATION — City or Town, State <b>BALTO., MD. 21202</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>HENRY W. JENKINS &amp; SONS 4905 YORK ROAD, BALTIMORE, MD. 21212</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Pulmonary Embolism / Urosepsis</b> <span style="float: right;">5-6 days</span> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Atrial Fibrillation (Intermittent)</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Myocardial Ischemia</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>GI Bleed (slow, intermittent)</b>					
Approximate Interval Between Onset and Death		e. <b>~12 hrs</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>End Stage Alzheimers Disease</b> <b>SIP CVA</b>							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>95009</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Seema Khan, MD JHBmc - Internal Medicine Dept</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>		32. OFFICE OF THE REGISTRAR					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14827

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LAURENCE R. HOUSTON</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>11</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>1:55 PM</b>	
4. SOCIAL SECURITY NUMBER <b>212-03-3784</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>93</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3/5/1902</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>6401 BELVEDERE AVE</b>				10f. ZIP CODE <b>21239</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>INSURANCE MGR.</b>		16b. KIND OF BUSINESS/INDUSTRY <b>INSURANCE</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JAMES R. HOUSTON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>GRACE DAVIS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ALAN N. HOUSTON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>109 CASTLEWOOD CIR. HYANNIS, CAPE COD, MS. 02601.</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>LORRAINE PARK CEMETERY 5/95</b>		20c. LOCATION — City or Town, State <b>BALTO., MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William R. Davis</i>				22. NAME AND ADDRESS OF FACILITY <b>HENRY W. JENKINS &amp; SONS CO. 4905 YORK RD. BALTO., MD. 21212.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>ASPIRATION PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>&gt; 3 DAYS</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ACUTE RENAL FAILURE</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>BARBARA WEDESMAN-SANICO, MD</b>				29c. LICENSE NUMBER <b>P-08240</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 11, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>BARBARA WEDESMAN-SANICO, MD 5601 LOCH RAVEN BLVD, BALTIMORE, MD 21239</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julia Hudson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14828

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GERTRUDE ESTELLE JEFFRES				2. DATE OF DEATH MONTH DAY YEAR MAY 14, 1995		3. TIME OF DEATH 2:30 A. M.	
4. SOCIAL SECURITY NUMBER 215-07-2697		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 94 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAR. 17, 1901	
9a. FACILITY NAME (If not institution, give street and number) CATON MANOR NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH BALTIMORE CITY	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION PASADENA		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1568 FAIRVIEW ROAD				10f. ZIP CODE 21122		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH GRADE College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY HOMEMAKING			
17. FATHER'S NAME (First, Middle, Last) WILLIAM FREDERICK LaBONTE				18. MOTHER'S NAME (First, Middle, Maiden Surname) IDA VILLA HINTON			
19a. INFORMANT'S NAME (Type/Print) MRS. HARRIET J. MEUSHAW				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1568 FAIRVIEW ROAD - PASADENA, MD 21122			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		DATE 5/17		20c. LOCATION — City or Town, State BALTIMORE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jackie H. Shannon</i>				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. — chronic bronchitis					Approximate interval Between Onset and Death < 1 yr.
		b. — rheumatoid disease					10 yrs
		c. — resolving pneumonia					< 1 mo.
		d. — Alzheimer's type Dementia					< 1 yr.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Marcelino Alburine</i> physician				29c. LICENSE NUMBER D29769		29d. DATE SIGNED (Month, Day, Year) 5/15/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. MARCELINO ALBURINE - 516 N. ROLLING ROAD - SUITE 204 - CATONSVILLE, MD 21228							
31. DATE FILED (Month, Day, Year) MAY 16 1995				32. REGISTRAR SIGNATURE <i>John A. Rader</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14829

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Dorothy Lee James</i>				2. DATE OF DEATH MONTH <i>May</i> DAY <i>10</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>1:00 P.M.</i>	
4. SOCIAL SECURITY NUMBER <i>051-30-0496</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <i>Aug 27, 1931</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>3415 Gwynns Falls Parkway</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Balto</i>		9c. COUNTY OF DEATH <i>N/A</i>	
10a. STATE <i>MD</i>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>Balto</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>3415 Gwynns Falls Parkway</i>				10f. ZIP CODE <i>21216</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th grade</i> College (1-4 or 5+) <i>NA</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Data Key Punch Operator</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Baltimore City Jail</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Hudson Pratt</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Annie Gladden</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Keith James</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3415 Gwynns Falls Parkway Balto, MD 21216</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Western Star Cem 5/13/95</i>		20c. LOCATION — City or Town, State <i>Catonsville, MD</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wm Eilman</i>				22. NAME AND ADDRESS OF FACILITY <i>March F.H. West 4300 Wabash Ave Balto, MD 21215</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia, congestive, congestive, congestive</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Due to (OR AS A CONSEQUENCE OF):</i> <i>congestive</i> b. <i>Due to (OR AS A CONSEQUENCE OF):</i> <i>MAC</i> c. <i>Due to (OR AS A CONSEQUENCE OF):</i> <i>ADSc PCP &amp; congestive</i> d. <i>Due to (OR AS A CONSEQUENCE OF):</i> <i>congestive</i>							Approximate Interval Between Onset and Death <i>2 wk</i> <i>1 mo</i> <i>7</i> <i>28</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James</i>				29c. LICENSE NUMBER <i>M05224</i>		29d. DATE SIGNED (Month, Day, Year) <i>5/11/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) <i>John Court 222, Baltimore 21208</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 16 1995</i>		32. REGISTRAR'S SIGNATURE <i>John Court</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14830

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BERNADETTE JOHNSON</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>10</b> , YEAR <b>1995</b>		3. TIME OF DEATH <b>4:30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>214-90-9409</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>20</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	7. DATE OF BIRTH (Month, Day, Year) <b>10-23-1974</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>BALTIMORE, MD.</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>CITY</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1107 WINCHESTER STREET</b>				10f. ZIP CODE <b>21217</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNKNOWN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>UNKNOWN</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOHN HOWARD</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY JOHNSON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MARY JOHNSON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1336 S. HANOVER STREET, BALTIMORE, MARYLAND 21230</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. ZION CEMETERY 5/15/95</b>		DATE <b>5/15/95</b>		20c. LOCATION — City or Town, State <b>LANSDOWN, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MD. 21217</b>			
23. PART I: Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Septic</b>  Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>retroviral infection</b> <b>cardio pulmonary arrest</b>							Approximate Interval Between Onset and Death <b>1 week</b> <b>7 years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>hepes simplex virus, seizure, chronic renal insufficiency</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Resident Physician</b>				29c. LICENSE NUMBER <b>L9768</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/16/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) <b>S. NAJJAR Tower 110 Johns Hopkins Hospital, Baltimore MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14831

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOSEPHINE MARY JOHNSTON</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 14, 1995</b>		3. TIME OF DEATH <b>12:38 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>219 16 5502</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 8, 1922</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Stella Maris Hospice</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		8c. COUNTY OF DEATH <b>Baltimore</b>	
9. RESIDENCE OF DECEDENT				10. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
10e. STREET AND NUMBER <b>53 B2 Beech Dr.</b>				10f. ZIP CODE <b>21220</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Domestic</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Samuel Flaherty</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary (unknown)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Patricia Hommel</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8249 Springs Rd., Warrenton VA 22186</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Green Mount Crematory 5/15/94</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>		20d. DATE <b>5/15/94</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen D. Lohrmann</i>				22. NAME AND ADDRESS OF FACILITY <b>CAFA Stephen D. Lohrmann P.A. 21286 8717 Green Pastures Dr., Baltimore, MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>BREAST CANCER</b> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>4 yrs.</b>							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC LUNG DISEASE</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <b>Hospice</b>					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kendall Faulkner</i>				29c. LICENSE NUMBER <b>D25643</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/15/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <i>J. H. Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 14832

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ETTA J. KAPLAN</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>14</b> , YEAR <b>1995</b>		3. TIME OF DEATH <b>1:10am</b> M	
4. SOCIAL SECURITY NUMBER <b>220-48-8716</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>SEPT. 14, 1906</b>	
8. BIRTHPLACE (State or Foreign Country) <b>NEW YORK</b>				9a. FACILITY NAME (If not institution, give street and number) <b>3505 FALLSTAFF RD.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>N/A</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>3505 FALLSTAFF RD.</b>	
10f. ZIP CODE <b>21215</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>AT HOME</b>	
17. FATHER'S NAME (First, Middle, Last) <b>ISAAC JACOB JENKINS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BESSIE ESKOWITZ</b>			
19a. INFORMANT'S NAME (Type/Print) <b>DR. LOUIS L. KAPLAN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3505 FALLSTAFF RD. BALTIMORE, MD 21215</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CHIZUK AMONO 5-15-1995 BALTIMORE, MD</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ellen Sue Levinson</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>aspiration pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>cerebrovascular accident</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>mitral valve disease, arterial fibrillation</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard A. Berg</i>				29c. LICENSE NUMBER <b>D20664</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/15/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Richard A. Berg, MD #306, 4000 Old Court Rd, Pikesville, Md 21208</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>JEFFERY JEFFREY PETER KLOSE JR.</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>15</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>9:44 A</b>	
4. SOCIAL SECURITY NUMBER <b>212-17-0505</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>20</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 7, 1975</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>BELLONA AVENUE &amp; RIDERVALE ROAD</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Lutherville</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>213 Meadowvale Road</b>				10f. ZIP CODE <b>21093</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>12</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Auto Mechanic</b>		16b. KIND OF BUSINESS/INDUSTRY <b></b>			
17. FATHER'S NAME (First, Middle, Last) <b>Jeffrey Peter Klose Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Joanne Kiser</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Jeffrey P. Klose Sr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>213 Meadowvale Road Lutherville, Md. 21093</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem. 5/18/95</b>		20c. LOCATION — City or Town, State <b>Timonium, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James J. Gladden</i>				22. NAME AND ADDRESS OF FACILITY <b>Ruck Towson Funeral Home Inc. 1050 York Rd. 21204</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Multiple Injuries</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b></b> b. <b></b> c. <b></b> d. <b></b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>ROADWAY</b>		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>5-15-95</b>		28b. TIME OF INJURY <b>0000 M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>Driver - auto, auto collision</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Roadway</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>Bellona + Ridervale Rds Towson</b>	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David R Fowler</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 15, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			





REG. NO.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

OHMM-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>LOUIS F KRAUSE</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>9</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>3 P.</b>	
4. SOCIAL SECURITY NUMBER <b>212-09-2202</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>92</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	7. DATE OF BIRTH (Month, Day, Year) <b>MAY 29, 1902</b>	
8. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEASED							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6407 APOLLO DR., APT. C</b>				10f. ZIP CODE <b>21209</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		15a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MANAGER</b>		15b. KIND OF BUSINESS/INDUSTRY <b>LIFE INSURANCE CO.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>FISHEL KRAUSE</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ETTA SHIFRA UNKNOWN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MR. WILFRED KRAUSE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8219 STREAMWOOD DR. BALTO., MD 21208</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BETH TFILOH 5/11/95</b>		DATE <b>5/11/95</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERTOWN RD. BALTO., MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute MI</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>ASCVD</b>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Spontaneous cell Ca</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER <b>D 27569</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>William Bettelmann 1777 Rister town Rd #365</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>SADIE L KAUFMAN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 9, 1995</b>		3. TIME OF DEATH <b>7:05 P M</b>	
4. SOCIAL SECURITY NUMBER <b>578-16-9719</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT. 23, 1907</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>3600 LABYRINTH RD., APT. B-1</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>MARYLAND</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3600 LABYRINTH RD., APT. B-1</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>AT HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>MAURICE Lesnar</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ROSE Mondress UNKNOWN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MR. ROBERT KAUFMAN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8816 STEPHANIE RD. RANDALLSTOWN, MD 21133</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MOSES MONTEFIORE WOODMOOR HEBREW 5/12/95 BALTO., MD</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ellensue Levinson</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERTOWN RD. BALTO., MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Coronary Occlusion</b> Approximate Interval Between Onset and Death <b>minutes</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Alciv</b> <b>Chronic obstructive lung disease</b> Approximate Interval Between Onset and Death <b>11 years</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic obstructive lung disease</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joseph Shear MD</i>				29c. LICENSE NUMBER <b>D10034</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOSEPH SHEAR MD 4000 OLD COURT ROAD 301 BALD MD 2103</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>		32. REGISTRAR'S SIGNATURE <i>John A. Shivers</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

3

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14837

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>James W. Kavanagh</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 13 1995</b>		3. TIME OF DEATH <b>2:00 A. M.</b>	
4. SOCIAL SECURITY NUMBER <b>217 03 0229 A</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>79</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>June 4, 1915</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>408 Ben Oaks Drive</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Severna Park</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>520 Maude Avenue</b>				10f. ZIP CODE <b>21225</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Mechanic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Martin Marietta</b>			
17. FATHER'S NAME (First, Middle, Last) <b>James J. Kavanagh</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Katherine M. McDonough</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Robert Kavanagh</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>408 Ben Oaks Drive Severna Park, Maryland 21146</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holy Cross Cemetery</b>		DATE <b>5/17</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SQUAMOUS CELL CARCINOMA</b> DUE TO (OR AS A CONSEQUENCE OF): <b>METASTATIC CANCER</b> DUE TO (OR AS A CONSEQUENCE OF): <b>HYPERCALCEMIA</b> DUE TO (OR AS A CONSEQUENCE OF): <b>POLYCYTHEMIA</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				29. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>George H. Yoo, M.D.</b>				29c. LICENSE NUMBER <b>D45141</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/15/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>George H. Yoo, M.D.</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.




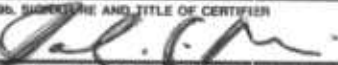



95 14838

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) <b>ANN MARY KAMINSKI</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 11, 1995</b>		3. TIME OF DEATH <b>4:30 A M</b>	
4. SOCIAL SECURITY NUMBER <b>220-14-8000</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 5, 1925</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Fallston General Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Fallston, Maryland</b>	
9c. COUNTY OF DEATH <b>Harford</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>	
10c. CITY, TOWN OR LOCATION <b>Jarrettsville</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1816 Trout Farm Road</b>	
10f. ZIP CODE <b>21084</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Anthony Puglese</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Barbareno</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Milton M. Kaminski</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1816 Trout Farm Rd. Jarrettsville, MD 21084</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holly Hill Mem. Gardens 5/12/1995 Baltimore, MD</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Bruzdinski Funeral Home P.A. 1407 Old Eastern Ave Balt., MD. 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
1. <b>CONGESTIVE HEART FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF):							
2. <b>RENAL FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF):							
3. <b>CORONARY ARTERY DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF):							
4. <b>SEPSIS</b>							
Approximate Interval Between Onset and Death (two) weeks (two) weeks (three) years (two) weeks							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS, HYPERTENSION, CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>037517</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 11, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. DAVID RUBIN 104 PLUMTREE ROAD, SUITE 110, BELAIR, MD 21015</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14839

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Emma J. Lovett</i>				2. DATE OF DEATH MONTH <i>5</i> DAY <i>12</i> YEAR <i>95</i>		3. TIME OF DEATH <i>1630 P M</i>	
4. SOCIAL SECURITY NUMBER <i>217-14-9265</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>60</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>AUG. 21, 1934</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>UNIVERSITY HOSPITAL</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE CITY</i>		9c. COUNTY OF DEATH <i>n/a</i>	
10a. STATE <i>MARYLAND</i>				10b. COUNTY <i>n/a</i>		10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>2612 KIRK AVENUE</i>			
10f. ZIP CODE <i>21218</i>				10g. CITIZEN OF WHAT COUNTRY? <i>UNITED STATES</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>3 RD</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HOUSEWIFE</i>		15b. KIND OF BUSINESS/INDUSTRY <i>in own home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>WALTER HOPPER</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>BERTHA HOOPER</i>			
19a. INFORMANT'S NAME (Type/Print) <i>FLORENCE GATES</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2536 ROBB STREET, BALTIMORE, MARYLAND 21218</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>WOODLAWN CEMETERY</i>		20c. LOCATION — City or Town, State <i>BALTIMORE, MARYLAND</i>		20d. DATE <i>5-17</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen E. Harris</i>				22. NAME AND ADDRESS OF FACILITY <i>WM.C. AMRCH FH.-1101 E. NORTH A VENUE</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Massive Intracerebral Hemorrhage</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John M. D.</i>				29c. LICENSE NUMBER <i>2818</i>		29d. DATE SIGNED (Month, Day, Year) <i>5/12/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Robert Thacker 22 S. Greene St. Baltimore, Md 21201</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 16 1995</i>				32. REGISTRAR'S SIGNATURE <i>John M. D.</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME <i>Cecilia L. Liberto</i>				2. DATE OF DEATH MONTH <i>May</i> DAY <i>11</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>5:20 A M</i>	
4. SOCIAL SECURITY NUMBER <i>213-12-2204</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>87</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>DEC. 23, 1907</i>	
8. BIRTHPLACE (State or Foreign Country) <i>PENNSYLVANIA</i>				9a. FACILITY NAME (If not institution, give street and number) <i>ST. AGNES HOSPITAL</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i>	
9c. COUNTY OF DEATH <i>BALTIMORE CITY</i>				10a. STATE <i>MARYLAND</i>		10b. COUNTY <i>BALTIMORE CITY</i>	
10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>406 SWANN AVENUE</i>	
10f. ZIP CODE <i>21229</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>7TH GRADE</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HOMEMAKER</i>		16b. KIND OF BUSINESS/INDUSTRY <i>HOMEMAKING</i>	
17. FATHER'S NAME (First, Middle, Last) <i>STANLEY KOWALSKI</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>SOPHIE KOWALKOWSKI</i>			
19a. INFORMANT'S NAME (Type/Print) <i>MRS. ROSE M. SICA</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>406 SWANN AVENUE - BALTIMORE, MD 21229</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>LOUDON PARK CEMETERY 5/15</i>		20c. LOCATION — City or Town, State <i>BALTIMORE</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James L. Klug</i>				22. NAME AND ADDRESS OF FACILITY <i>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia (aspiration)</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death <i>1 week</i> <i>3 years</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Colon cancer, Peripheral vascular disease</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>RESIDENT</i>				29c. LICENSE NUMBER <i>2061</i>		29d. DATE SIGNED (Month, Day, Year) <i>MAY 11 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>300 CATON AVE BALTIMORE MD 21229 / GEORGE FARES</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 16 1995</i>				32. REGISTRAR'S SIGNATURE <i>John A. Wilkins-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14841

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Gregory D. Lewis</i>				2. DATE OF DEATH MONTH <i>May</i> DAY <i>14</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>11:30 p.m.</i>	
4. SOCIAL SECURITY NUMBER <i>129-48-7714</i>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>35</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>November 6, 1959</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Connecticut</i>				9a. FACILITY NAME (If not institution, give street and number) <i>135 Willowbend Drive</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Owings Mills</i>	
9c. COUNTY OF DEATH <i>Balto</i>				10a. STATE <i>Md</i>		10b. COUNTY <i>Baltimore</i>	
10c. CITY, TOWN OR LOCATION <i>Owings Mills</i>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>135 Willowbend Drive</i>	
10f. ZIP CODE <i>21117</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (14 or 5+) <i>N/A</i>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Mechanic</i>				16b. KIND OF BUSINESS/INDUSTRY <i>McCormick &amp; Co.</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Aphonso Lewis</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Jean Thompson</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Beverly Lewis</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>135 Willowbend Drive Owings Mills, Md 21117</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Garrison Forest Vet 5/14/95</i>			
20c. LOCATION — City or Town, State <i>Owings Mills, Md</i>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jerome A. Thompson Jr</i>			
22. NAME AND ADDRESS OF FACILITY <i>March F.H. West 4300 Wabash Avenue Balto Md 2121</i>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cancer Lung &amp; Mets</i>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Nomicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dee C. Bull</i>				29c. LICENSE NUMBER <i>806480</i>		29d. DATE SIGNED (Month, Day, Year) <i>5/15/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Dee C. Bull 10219 S. Delfield Rd Owings Mills, Md 21117</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 16 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Andrew Carroll</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

unpublished, 1978, 1980



95 14842

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Rose S. LaMonaco				2. DATE OF DEATH MONTH DAY YEAR May 14 1995		3. TIME OF DEATH 11:50 P. M	
4. SOCIAL SECURITY NUMBER 217-22-0392		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 92 YRS.	7. DATE OF BIRTH (Month, Day, Year) Jan. 25, 1903		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Home Severna Park				9b. CITY, TOWN OR LOCATION OF DEATH Severna Park		9c. COUNTY OF DEATH Anne Arundel	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Severan Park		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 24 Truck House Rd.				10f. ZIP CODE 21146		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Frank Guarilla				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Zampini			
19a. INFORMANT'S NAME (Type/Print) Frances Garber				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 52 Holly Road Severna Park, MD 21146			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Redeemer Cem. May 18, 1995		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Kirkley-Ruddick Funeral Home 421 Crain Hwy. S.E. Glen Burnie, MD 21061			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. INTRACTABLE CONGESTIVE HEART FAILURE					
		b. ISCHEMIC CARDIOMYOPATHY					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Attending				29c. LICENSE NUMBER D 21776		29d. DATE SIGNED (Month, Day, Year) 5/16/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Surva Mundra 1600 Crain Hwy. Suite 106 Glen Burnie, MD 21061							
31. DATE FILED (Month, Day, Year) MAY 16 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14843

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Walter Leibowitz				2. DATE OF DEATH MONTH DAY YEAR May 9, 1995				3. TIME OF DEATH 4:50p M					
4. SOCIAL SECURITY NUMBER 041 22 9667		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Sept. 17, 1929		8. BIRTHPLACE (State or Foreign Country) Connecticut			
9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda				9c. COUNTY OF DEATH Montgomery					
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Bethesda				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 10103 Langhorne Court				10f. ZIP CODE 20817				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE YEAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Caucasian					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Economist				16b. KIND OF BUSINESS/INDUSTRY US Government					
17. FATHER'S NAME (First, Middle, Last) Chaim Leibowitz						18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Klau							
19a. INFORMANT'S NAME (Type/Print) Ruth Spodak						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10 above							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Judean Mem. Gardens 5/11/95				20c. LOCATION — City or Town, State Olney, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>						22. NAME AND ADDRESS OF FACILITY Ives-Pearson Funeral Homes Falls Church, VA 22046							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>RESPIRATORY INSUFFICIENCY</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Pneumonia, ARDS</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death 2 MDS			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Arteriosclerotic vascular disease</u> <u>Renal failure</u>										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>						29c. LICENSE NUMBER D23190		29d. DATE SIGNED (Month, Day, Year) 5/9/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Louis Kozloff, M.D. 6218 Wisconsin Ave; Bethesda, MD 20814													
31. DATE FILED (Month, Day, Year) MAY 16 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Item 1. Film 723, 5/16/95, 1t

95 14844

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>ALEXANDER ALEXANDER MASON</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 11 95</b>		3. TIME OF DEATH <b>4:27 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>307-32-7498</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>60</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jul. 9, 1934</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Indiana</b>				9a. FACILITY NAME (If not Institution, give street and number) <b>310 E. 26th STREET</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>N/A</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>310 E. 26th Street</b>				10f. ZIP CODE <b>21218</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>12th</b> College (1-4 or 5+) <b>-</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Grinder</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Steel</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George Washington</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Alfreda Reynolds</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Lillian Mason</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>310 E. 26th Street/Baltimore, Maryland 21218</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest Va. Cem. 5/17</b>		20c. LOCATION — City or Town, State <b>Owings Mills, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Symette K. Jones</i>				22. NAME AND ADDRESS OF FACILITY <b>March Funeral Home East 1101 E. North Avenue/Baltimore, MD 21202</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>INSPECTION</b>	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Margaret Korell</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 12, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <i>Margaret Korell</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14845

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Evelyn M. McDonald</i>		2. DATE OF DEATH MONTH DAY YEAR <i>May 14 95</i>		3. TIME OF DEATH <i>7:45 P.M.</i>	
4. SOCIAL SECURITY NUMBER <i>218-01-4365A</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>77</i> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <i>AUG. 25, 1917</i>		8. BIRTHPLACE (State or Foreign Country) <i>S. CAROLINA</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>BON SECOUR HOSPITAL</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE CITY</i>		9c. COUNTY OF DEATH <i>n/a</i>	
10a. STATE <i>MARYLAND</i>		10b. COUNTY <i>n/a</i>		10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>2305 WINDSOR AVENUE</i>		10f. ZIP CODE <i>21216</i>	
10g. CITIZEN OF WHAT COUNTRY? <i>UNITED STATES</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>8 TH</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>COOK</i>		16b. KIND OF BUSINESS/INDUSTRY <i>RESTAURANT</i>	
17. FATHER'S NAME (First, Middle, Last) <i>JOHNNIE MC DONALD</i>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>JANIE DUNLAP</i>			
19a. INFORMANT'S NAME (Type/Print) <i>MARIE ENGLISH</i>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2305 WINDSOR AVENUE, BALTIMORE, MD 21216</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>GARDEN OF ETERNAL HOPE 5-18</i>		20c. LOCATION — City or Town, State <i>CARROLL CO, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lee V. Holland</i>		22. NAME AND ADDRESS OF FACILITY <i>WM. C. MARCH FH.-1101 E. NORTH AVENUE</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Lung Cancer with metastases</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. <i>Lung Cancer with metastases</i> b. <i>DUE TO (OR AS A CONSEQUENCE OF):</i> c. <i>DUE TO (OR AS A CONSEQUENCE OF):</i> d. <i>DUE TO (OR AS A CONSEQUENCE OF):</i>					Approximate Interval Between Onset and Death <i>1 mo</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypocalcemia</i>					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <i>5/14</i>		28b. TIME OF INJURY <i>1/2 M</i>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <i>n/a</i>		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>n/a</i>	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David R. Hennigan MD</i>		29c. LICENSE NUMBER <i>D43386</i>		29d. DATE SIGNED (Month, Day, Year) <i>5.14.95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>1530 Bolton St Baltimore, MD 21217</i>					
31. DATE FILED (Month, Day, Year) <i>MAY 16 1995</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ANDREI MELAMED</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 9 1995</b>		3. TIME OF DEATH <b>1:00 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>212-46-4075A</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>92</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>AUG. 26, 1902</b>	
8. BIRTHPLACE (State or Foreign Country) <b>ROMANIA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>N/A</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>7200 VALLEY COUNTRY CT. APT. B-4</b>	
10f. ZIP CODE <b>21208</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>X</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>TRANSLATOR</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Translator</b>		16b. KIND OF BUSINESS/INDUSTRY <b>BALTIMORE MUSEUM OF ART</b>	
17. FATHER'S NAME (First, Middle, Last) <b>BENJAMIN MELAMED</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BLANCHE SOLOMON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>RUTH LATHE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>901 DULANEY VALLEY RD, SUITE 400 TOWSON, MD 21204</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ARLINGTON -CHIZUK AMUNO 5-11-1995 BALTIMORE, MD</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott M. Cottle</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiomyopathy</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Cardiomyopathy</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>BASAL CELL CARCINOMA</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John A. Nevers</i> M.D.				29c. LICENSE NUMBER <b>AS2402321-JV9629</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 9, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) <b>Ibiza NEVARES 2401 West Belvedere, Baltimore MARYLAND 21215</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

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BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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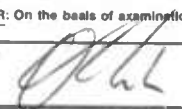

95-2793-510  
B.K.S

95 14847

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRANK W. MILLER, SR.				2. DATE OF DEATH MONTH DAY YEAR MAY 14, 1995				3. TIME OF DEATH 1718 P M			
4. SOCIAL SECURITY NUMBER 212-42-7291		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 49 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 23, 1945		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITAL S.T.U				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH BALTIMORE CITY			
10a. STATE MARYLAND				10b. COUNTY BALTIMORE CITY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 666 QUEENSGATE ROAD				10f. ZIP CODE 21229		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 YRS		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TRUCK DRIVER		16b. KIND OF BUSINESS/INDUSTRY ST. JOHNSBURY TRUCKING CO							
17. FATHER'S NAME (First, Middle, Last) NOLAN F. MILLER, SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) CATHERINE B. SMITH							
19a. INFORMANT'S NAME (Type/Print) FRANK W. MILLER, JR.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2234 EAGLE STREET - BALTIMORE, MD 21223							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		DATE 5/18		20c. LOCATION — City or Town, State BALTIMORE					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Contact Gun shot wound of Head DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Partial		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 5-13-95		28b. TIME OF INJURY 1056 M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED Subject shot self			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Residence				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 666 Queensgate Rd Baltimore					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E				29d. DATE SIGNED (Month, Day, Year) MAY 15, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) MAY 16 1995				32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14848

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edward Miklewski				2. DATE OF DEATH MONTH DAY YEAR May 15 95		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 276-26-1634		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 78 YRS.	7. DATE OF BIRTH (Month, Day, Year) 03/29/17		8. BIRTHPLACE (State or Foreign Country) Ohio	
9a. FACILITY NAME (If not institution, give street and number) 105 N. Milton Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 105 N. Milton Avenue				10f. ZIP CODE 21224		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter		16b. KIND OF BUSINESS/INDUSTRY Ship Yard			
17. FATHER'S NAME (First, Middle, Last) Frank Miklewski				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marion Antionette Lewandowski			
19a. INFORMANT'S NAME (Type/Print) Sue Barber				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 N. Milton Avenue, Balto., MD 21224			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Stanislaus Cem. 5/17		20c. LOCATION — City or Town, State Baltimore, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathleen Weber</i>				22. NAME AND ADDRESS OF FACILITY David J. Weber Funeral Home 401 S. Chester St., Balto., MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. Coronary Artery Disease							
DUE TO (OR AS A CONSEQUENCE OF):							
b. Ventricular Arrhythmias							
DUE TO (OR AS A CONSEQUENCE OF):							
c.							
DUE TO (OR AS A CONSEQUENCE OF):							
d.							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pulmonary emboli, Deep Vein Thrombosis, Stroke, monoclonal Gammopathy							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Susan Gorell Weiner MD</i>				29c. LICENSE NUMBER D34941		29d. DATE SIGNED (Month, Day, Year) 5-15-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SUSAN GORELL WEINER MD 5601 Loch Raven Blvd BALTIMORE, Md.							
31. DATE FILED (Month, Day, Year) MAY 10 1995		32. REGISTRAR'S SIGNATURE <i>J. [illegible]</i> 21239					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>ELIZABETH M. MILLER</u>				2. DATE OF DEATH MONTH <u>5</u> DAY <u>12</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>1215</u> PM	
4. SOCIAL SECURITY NUMBER <u>185-10-7417</u>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>82</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>JULY 15, 1912</u>	
8. BIRTHPLACE (State or Foreign Country) <u>PENNSYLVANIA</u>				9a. FACILITY NAME (If not institution, give street and number) <u>NORTH ARUNDEL HOSPITAL</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>GLEN BURNIE</u>	
9c. COUNTY OF DEATH <u>ANNE ARUNDEL</u>				10a. STATE <u>MARYLAND</u>		10b. COUNTY <u>MONTGOMERY</u>	
10c. CITY, TOWN OR LOCATION <u>GAITHERSBURG</u>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <u>7500 ELIOKA TERRACE</u>	
10f. ZIP CODE <u>20879</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>WHITE</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>0</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>HOMEMAKER</u>		16b. KIND OF BUSINESS/INDUSTRY <u>HOME</u>	
17. FATHER'S NAME (First, Middle, Last) <u>FRANCIS HEISEN MIESEN</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>SARA BACHMAN SARAH BACHMAN</u>			
19a. INFORMANT'S NAME (Type/Print) <u>GORDON C. MILLER</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>7500 ELIOKA TERRACE, GAITHERSBURG, MARYLAND 20879</u>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>BALTIMORE WASHINGTON CREMATORY 5/13</u>		20c. LOCATION — City or Town, State <u>LAUREL, MARYLAND</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY <u>FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>UROSEPSIS</u> Due to (OR AS A CONSEQUENCE OF): a. <u>CEREBROVASCULAR ACCIDENT</u> Due to (OR AS A CONSEQUENCE OF): b. <u>HYPERTENSION</u> Due to (OR AS A CONSEQUENCE OF): c. <u>HYPOTHYROIDISM</u> Due to (OR AS A CONSEQUENCE OF): d. <u>HYPOTHYROIDISM</u> Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature] MEDICAL HOME OFFICER</u>				29c. LICENSE NUMBER <u>D43477</u>		29d. DATE SIGNED (Month, Day, Year) <u>MAY 12<sup>th</sup> '95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>ANDREA DIKETUNO, NASH 301 HOSP. DR. GLEN BURNIE MD 21061</u>							
31. DATE FILED (Month, Day, Year) <u>MAY 16 1995</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14850

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Helen W. Moore</b>				2. DATE OF DEATH MONTH <b>05</b> DAY <b>15</b> YEAR <b>95</b>		3. TIME OF DEATH <b>730 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>194-18-9958</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>91</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>APRIL 7, 1904</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>MARINER HEALTH CARE OF GREATER LAUREL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>LAUREL</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGE</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>HOWARD</b>		10c. CITY, TOWN OR LOCATION <b>COLUMBIA</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7385 EDEN BROOK DRIVE</b>				10f. ZIP CODE <b>21046</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>EXECUTIVE SECRETARY</b>		16b. KIND OF BUSINESS/INDUSTRY <b>PHILADELPHIA PRESBYTERY</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ALEXANDER WHITE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>URSULA SIMMS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CURTIS MOORE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7385 EDEN BROOK DRIVE, COLUMBIA, MARYLAND 21046</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BALTIMORE WASHINGTON CREMATORY</b>		20c. LOCATION — City or Town, State <b>LAUREL, MARYLAND</b>		20d. LOCATION — City or Town, State <b>LAUREL, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b>						<b>1 week</b>	
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						<b>year</b>	
b. <b>Organic brain syndrome</b>							
c. <b>Due to (OR AS A CONSEQUENCE OF):</b>							
d. <b>Due to (OR AS A CONSEQUENCE OF):</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>congestive heart failure</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>042767</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/15/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Chris Moore 1408 17th Ave Laurel MD 20707</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95-2776-003

DWG

Item#19.b. G-film 723 per F.H 5/16/95 P.C

95 14851

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARIA NMN MALYK				2. DATE OF DEATH MONTH DAY YEAR MAY 12 95		3. TIME OF DEATH 3:12P M	
4. SOCIAL SECURITY NUMBER 214-38-6597		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 29, 1914	
8. BIRTHPLACE (State or Foreign Country) Ukraine							
9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASS.				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE		9c. COUNTY OF DEATH ANNE ARUNDEL	
10a. STATE Maryland				10b. COUNTY A.A.Co.		10c. CITY, TOWN OR LOCATION Pasadena, Md.	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 8371 Baltimore, Annapolis Blvd.				10f. ZIP CODE 21122		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th Grade		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Peter Falczyk				18. MOTHER'S NAME (First, Middle, Maiden Surname) Melania Turick			
19a. INFORMANT'S NAME (Type/Print) Mr. Harry G. Malyk				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City, State, ZIP Code) 8371 Baltimore & Annapolis Blvd. Annapolis, MD 21122			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Cross Cemetery, 5/17/95		20c. LOCATION — City or Town, State Brooklyn Park, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harold A. Taylor</i>				22. NAME AND ADDRESS OF FACILITY Balto. Md. 21225 Ave. McCully Funeral Home, 237 E. Patapsco			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Multiple Injuries</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 3-12-95		28b. TIME OF INJURY 1437M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <i>pedestrian hit by truck</i>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>street</i>					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>North of Diman Rd. Annapolis Blvd. A.A.C. Md</i>							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chute MD</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) MAY 13/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND 21201							
31. DATE FILED (Month, Day, Year) MAY 16 1995		32. REGISTRAR'S SIGNATURE <i>John A. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14852

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KATHERINE MILBURN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 10, 1995</b>		3. TIME OF DEATH <b>6AM M</b>	
4. SOCIAL SECURITY NUMBER <b>217-24-4342</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>66 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>DEC. 16, 1928</b>	
8. BIRTHPLACE (State or Foreign Country) <b>VIRGINIA</b>				9. FACILITY NAME (If not institution, give street and number) <b>4702 WOODLEA AVE.</b>			
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>4702 WOODLEA AVE.</b>			
10f. ZIP CODE <b>21206</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: <b>X</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>MASTERS DEGREE</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SOCIAL WORKER SUPERVISOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>BALTIMORE CITY</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JAMES WINMOND</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>IDA MAE EDWARDS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>REGINALD WINMOND</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4702 WOODLEA AVE. BALTO, MD. 21206</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ARBUTUS MEMORIAL PK. 5-17-95 BALTO, MD.</b>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin B. Scruggs Jr.</i>				22. NAME AND ADDRESS OF FACILITY <b>CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Gross Abscess with Renal Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Metastatic Disease of Abdomen</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): <b>UNCONTROLLED DIABETES MELLITUS, HRP</b> <b>Periphereal VASCULAR Disease</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <b>Home</b>			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Shadeck K. Rhoton MD Attending</i>				29c. LICENSE NUMBER <b>015300</b>		29d. DATE SIGNED (Month, Day, Year) <b>5-10-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Shadeck K. Rhoton MD 6609 Reisterstown Rd BALTO, MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Andrew Radell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14853

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CLARENCE MERTON MORGAN</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>9</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>1810</b>	
4. SOCIAL SECURITY NUMBER <b>213-01-6302</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-13-1908</b>	
8. BIRTHPLACE (State or Foreign Country) <b>PENNSYLVANIA</b>				9a. FACILITY NAME (If not Institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>N/A</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>MARYLAND</b>			
10b. COUNTY <b>CARROLL</b>		10c. CITY, TOWN OR LOCATION <b>SYKESVILLE</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>7200 3RD AVE</b>	
10f. ZIP CODE <b>21784</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ENGINEER</b>	
16b. KIND OF BUSINESS/INDUSTRY <b>ENGINEER</b>		17. FATHER'S NAME (First, Middle, Last) <b>MERTON WALLACE MORGAN</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CAROLYN FULLER</b>		19a. INFORMANT'S NAME (Type/Print) <b>FRANK MORGAN</b>	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>410 CEDARCROFT RD. BALTO., MD. 21212.</b>		20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ST. DAVIDS NICHE 5/95</b>		20c. LOCATION — City or Town, State <b>BALTO., MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William K. Quetzler</i>		22. NAME AND ADDRESS OF FACILITY <b>HENRY W. JENKINS &amp; SONS CO. 4905 YORK RD. BALTO., MD. 21212.</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RESPIRATORY FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>COPD AND CHF</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  <b>ATRIAL FIBRILLATION</b>		Approximate Interval Between Onset and Death <b>DAYS</b> <b>YEARS.</b>	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>C. Ravi MD</i>		29c. LICENSE NUMBER <b>D37333</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 9, 1995</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>C. RAVI MD, NHC, BALTO. MD 21133</b>	
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>		32. REGISTRAR'S SIGNATURE <i>John A. Randall</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

MAY 1 1986  
U.S. DEPARTMENT OF AGRICULTURE



95 14854

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROBERT C. McLAIN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 13, 1995</b>		3. TIME OF DEATH <b>9:15 aM</b>	
4. SOCIAL SECURITY NUMBER <b>245-01-3175</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 15, 1914</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Tennessee</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Rossville</b>	
9c. COUNTY OF DEATH <b>Baltimore County</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Essex</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>758 Mansfield Road</b>	
10f. ZIP CODE <b>21221</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Farmer</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Farmer</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Farming</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Rubin McClain</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Minnie Kirkland</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Sally Neal</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>758 Mansfield Rd. Baltimore, MD 21221</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Greenmount Crematory 5/16/95</b>			
20c. LOCATION — City or Town, State <b>Baltimore City</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>			
22. NAME AND ADDRESS OF FACILITY <b>Bruzdzinski Funeral Home P.A. 1407 Old Eastern Ave. Balt. MD. 21221</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Chronic Obstructive Pulmonary Disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Atherosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>bladder cancer, hypertension, hip fracture 9/8/95, previous myocardial infarction</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>5/13/95</b>			
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>Dr. J. C. ...</b>			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D41680</b>			
29d. DATE SIGNED (Month, Day, Year) <b>5/13/95</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Adolph Wychulis, M.D. 404-406 Eastern Avenue, Baltimore, MD 21221</b>			
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Chadwick 2/1/7

95 14855

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Thomas E. McComas</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>15</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>9:45 A M</b>	
4. SOCIAL SECURITY NUMBER <b>219-03-4312</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>October 21, 1918</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>North Arundel Hospital</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Glen Burnie</b>		8c. COUNTY OF DEATH <b>Anne Arundel</b>	
9. RESIDENCE OF DECEDENT				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Essex</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>932 Martin Road</b>				10f. ZIP CODE <b>21221</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Machinist</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Container Manufacturing</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Joseph McComas</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Catherine Derwart</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Nancy Thrush</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>611 Rosello Peace Glen Burnie, MD. 21061</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery 5/18/95</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Bruzdzinski Funeral Home P.A. 1407 Old Eastern Ave. Balt. MD. 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ruptured Abdominal Aortic Aneurysm</b> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>15 days</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MEDICAL HOME OFFICER				29c. LICENSE NUMBER <b>D43977</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 15<sup>th</sup> '95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ANDREW ORESTO, NATH 301 HOSP. DRIVE, GLEN BURNIE MD 21061.</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14856

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES A. MILES</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 13 1995</b>		3. TIME OF DEATH <b>4:30 A M</b>	
4. SOCIAL SECURITY NUMBER <b>365-38-8863</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>63</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 4, 1932</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Michigan</b>				9a. FACILITY NAME (If not institution, give street and number) <b>2605 Page Drive</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Dundalk</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Dundalk</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>2605 Page Drive</b>	
10f. ZIP CODE <b>21222</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Agricultural Tech</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Agriculture</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Frederick G. Miles</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ilene May Wilbur</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Susan Kraus</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2605 Page Drive Baltimore, Md 21222</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery 5-16</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Anthony Colt Connelly</b>	
22. NAME AND ADDRESS OF FACILITY <b>Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222</b>		23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. Glioblastoma Multiforme</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>				Approximate Interval Between Onset and Death <b>one month</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus, Peripheral Vascular dz, Tobacco</b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Janice Ryden</b>		29c. LICENSE NUMBER <b>D40609</b>	
29d. DATE SIGNED (Month, Day, Year) <b>5/15/95</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Janice Ryden M.D. 1005 North Point Blvd. Baltimore, Md. 21224</b>			
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <b>John D. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14857

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Laura Norris</b>				2. DATE OF DEATH MONTH <b>05</b> DAY <b>14</b> YEAR <b>95</b>				3. TIME OF DEATH <b>0320 AM</b>	
4. SOCIAL SECURITY NUMBER <b>214 22 4013</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JAN. 30 1924</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5037 PEMBRIDGE AVENUE</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S. OF A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOME MAKER</b>			16b. KIND OF BUSINESS/INDUSTRY <b>UNKNOWN</b>		
17. FATHER'S NAME (First, Middle, Last) <b>AUSTIN A. BRECKENRIDGE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LAURA FAIRFAX</b>					
19a. INFORMANT'S NAME (Type/Print) <b>MR. JAMES A. LITTLE, SR.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5037 PEMBRIDGE AVE. BALTIMORE, MD. 21215</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest Vet Cem 5/18/95</b>				20c. LOCATION — City or Town, State <b>Owings Mills, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Lewis T. Gwynn</b>				22. NAME AND ADDRESS OF FACILITY <b>LEWIS T. GWYNN FUNERAL HOME 21215 4517 PARK HEIGHTS AVE. BALTO., MD.</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardio-respiratory arrest</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Hypoventilation syndrome</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>End stage renal disease</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Cerebrovascular disease</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate interval between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atrial Fibrillation</b> <b>Morbid Obesity</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Ira N. Mandell M.D.</b>				29c. LICENSE NUMBER <b>D22833</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/16/95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ira N. Mandell, M.D. 1818 Pot Spring Rd. #102, Lutherville, MD 21093</b>									
31. DATE SIGNED (Month, Day, Year) <b>MAY 16 1995</b>		32. REGISTRAR'S SIGNATURE <b>J. L. [Signature]</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

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1900-1901 1902-1903 1904-1905

1906-1907 1908-1909



95 14858

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Anna Marie Noll				2. DATE OF DEATH MONTH DAY YEAR May 11 1995				3. TIME OF DEATH 5:20am M	
4. SOCIAL SECURITY NUMBER 138-26-7789		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 91 YRS.	7. DATE OF BIRTH (Month, Day, Year) March 31, 1904		8. BIRTHPLACE (State or Foreign Country) Romania			
9a. FACILITY NAME (If not institution, give street and number) Stella Maris				9b. CITY, TOWN OR LOCATION OF DEATH Towson				9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Lutherville			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 2229 West Joppa Rd.				10f. ZIP CODE 21093	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 yrs College (14 or 5+) College	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife				16b. KIND OF BUSINESS/INDUSTRY Own Home				17. FATHER'S NAME (First, Middle, Last) Frank Prohammer	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Durst				19a. INFORMANT'S NAME (Type/Print) Eleanor Noll				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2229 West Joppa Rd. Lutherville, Md. 21093	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Gertrude				20c. LOCATION — City or Town, State 5-16 Woodbridge, N.J.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 15506	
29d. DATE SIGNED (Month, Day, Year) May 11 1995				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Nakhuda 2300 Dulany Valley Road Towson, Md 21204				31. DATE FILED (Month, Day, Year) MAY 16 1995	
32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KATHERINE D NEARER</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>11<sup>th</sup></b> YEAR <b>95</b>		3. TIME OF DEATH <b>7:22 P M</b>	
4. SOCIAL SECURITY NUMBER <b>214 22 6712</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10<sup>th</sup> MAR 1923</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>FALLSTON GENERAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>HARFORD</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>HARFORD</b>		10c. CITY, TOWN OR LOCATION <b>BELAIR</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>208 HAYS STREET</b>			
10f. ZIP CODE <b>21014</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK.</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>12th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNKNOWN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>UNKNOWN</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ALBERT H. McCLANAHAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>HATTIE BANKS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ROBERT E. WILLIAMS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3316 LYNNE HAVEN DRIVE RANDALLSTOWN MD 21244</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) <b>METRO CREMATORY</b>		20c. LOCATION — City or Town, State <b>51395 BALTO. MD</b>		22. NAME AND ADDRESS OF FACILITY <b>MARCH FUNERAL HOME-WEST 4300 WABASH AVE. BALTO. MD 21215</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ACUTE CORONARY ARTERY DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. A.C.W.D.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>			
23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>NA</b>		28b. TIME OF INJURY <b>NA M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>NA</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>NA</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>NA</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> <b>OME</b>		29c. LICENSE NUMBER <b>021809</b>	
29d. DATE SIGNED (Month, Day, Year) <b>MAY 11 95.</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>G PRACHU 1810 BELAIR RD #102 FALLSTON MD 21047-879-6584</b>			
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

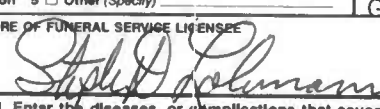
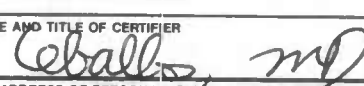
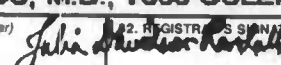
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14860

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WENDELL E. NORRIS JR.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 15 1995</b>		3. TIME OF DEATH <b>7:50 am</b>	
4. SOCIAL SECURITY NUMBER <b>213 34 9351</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>56</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 1, 1939</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Saint Joseph Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson, Maryland</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>517 E.41st St.</b>	
10f. ZIP CODE <b>21218</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Accountant / Personnel</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Medical Facility</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Wendell E. Norris</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Helen Thelma Wright</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Barbara Jean Norris</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>517 E.41st St., Baltimore, MD 21218</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Green Mount Crematory 5/16/95</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore MD 21286</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. METASTATIC CARCINOMA OF THE COLON</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>PNEUMONIA</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>LILIA CEBALLOS, M.D.</b>				29c. LICENSE NUMBER <b>D 25886</b>		29d. DATE SIGNED (Month, Day, Year) <b>5.15.95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>LILIA CEBALLOS, M.D., 7505 OSLER DR., TOWSON, MD. 21204</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROBERTA D NELSON</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>13</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>6:46 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>236-28-4955</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 30, 1921</b>	
8. BIRTHPLACE (State or Foreign Country) <b>West Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Good Samaritan Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Essex</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>28 B Fenway South</b>	
10f. ZIP CODE <b>21221</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 8+) <b>Housewife</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Home</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>William Rayburn</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ella Hicks</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Anna Neil</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11 Branch Street Balt. MD. 21221</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holly Hill Mem. Gardens 5/16/1995 Baltimore, MD.</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Bruzdzinski Funeral Home P.A. 1407 Old Eastern Ave. Balt. MD. 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>probable cerebrovascular accident</b> b. <b>atherosclerotic vascular disease</b> c. <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> d. <b>probable Septic shock 2° to myocardial infarction</b> Approximate Interval Between Onset and Death <b>10 hrs</b> <b>several years</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>probable Septic shock 2° to myocardial infarction</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Liza L. ILAG, M.D.</b>				29c. LICENSE NUMBER <b>P07640</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 13, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>LIZA L. ILAG, GOOD SAMARITAN HOSPITAL, BALTO., MD 21239</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14862

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM F. PORTER</b>				2. DATE OF DEATH MONTH <b>05</b> DAY <b>13</b> YEAR <b>95</b>		3. TIME OF DEATH <b>5:59 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>215-28-9742</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 11, 1932</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Sinai Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>n/a</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Owings Mills</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5 Pine Spring Lane</b>				10f. ZIP CODE <b>21117</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 yrs</b> College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Electrical Contractor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Contractor</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William Francis Porter</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Florence Carrie Bevans</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Joan L. Porter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 Pine Spring Lane Owings Mills, Md. 21117</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley</b>		DATE <b>5-17</b>		20c. LOCATION — City or Town, State <b>Timonium, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>II. MYOCARDIAL INFARCTION</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death <b>30 min</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE NOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER  <b>MARCEL DEVETTEN MD</b>				29c. LICENSE NUMBER <b>M 36485</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/13/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARCEL DEVETTEN M.D. SINAI HOSPITAL EMERGENCY MED.</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14863

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROBERT GEOFFREY PRATT</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>11</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>4 AM</b> <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>564-09-8035</b>		5. SEX <b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH MONTH <b>NOV.</b> DAY <b>9</b> YEAR <b>1920</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>111 HAMLET HILL RD, APT. 906</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>CALIFORNIA</b>				10b. COUNTY <b>SANTA CRUZ</b>		10c. CITY, TOWN OR LOCATION <b>CAPITOLA</b>	
10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>4855 JEWEL STREET</b>			
10f. ZIP CODE <b>95010</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>OWNER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>WHOLESALE BEAUTY PRODUCTS</b>	
17. FATHER'S NAME (First, Middle, Last) <b>HAROLD CORNELIUS PRATT</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>GABRIELLE KENNEDY</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. COLLEEN WALL</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6845 SHEARWATER DRIVE SAN JOSE, CA 95120</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input type="checkbox"/> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HILLTOP SERVICE CORP. 5-12-1995 TOWSON, MD</b>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ellenore Swenson</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cirrhosis of the Liver</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>							Approximate interval Between Onset and Death <b>12 yrs.</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Ascites, COPD</b>							24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>7</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Chambers MD</i>				29c. LICENSE NUMBER <b>028814</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/11/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>3105 N. Charles Street, Baltimore, MD 21218</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b> <i>J. A. [Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 14864

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>SIDNEY POLLACK</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 9, 1995</b>		3. TIME OF DEATH <b>9:20 P. M.</b>	
4. SOCIAL SECURITY NUMBER <b>217-16-8990</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>DEC. 22, 1921</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>3707 ELKANAH PLACE</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>RANDALLSTOWN</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>	
10c. CITY, TOWN OR LOCATION <b>RANDALLSTOWN</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>3707 ELKANAH PLACE</b>	
10f. ZIP CODE <b>21133</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE YEAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>9</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>COLLECTOR/SALESMAN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>INSTALLMENTS</b>			
17. FATHER'S NAME (First, Middle, Last) <b>DAVID POLLACK</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>SARAH WEITZMAN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. IRMA POLLACK</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3707 ELKANAH PLACE RANDALLSTOWN, MD 21133</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>LIBERTY PARK (SHAAREI ZION CONG.) 5/11/95 RANDALLSTOWN, MD</b>		20c. LOCATION — City or Town, State <b>MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Spel D Lewis</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERTOWN RD. BALTO., MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Aspiration Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Dysphagia</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Multiple systems atrophy ("ASODY")</b> DUE TO (OR AS A CONSEQUENCE OF): <b>neurologic degenerative disorder</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Tachycardia, autonomic neuropathy</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Allen M. Friedman MD</i>				29c. LICENSE NUMBER <b>D24888</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 10 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>4000 Old Court Rd #306 Balto MD 21208</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95-2766-510

DWG

95 14865

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>D. DONALD</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>12</b> YEAR <b>95</b>				3. TIME OF DEATH <b>0940A</b> M	
4. SOCIAL SECURITY NUMBER <b>140-12-2228</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>August 24, 1923</b>		8. BIRTHPLACE (State or Foreign Country) <b>New Jersey</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>ST. AGNES HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>				9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>FL</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Vero Beach</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>5300 N. A 1 A, Unit 310</b>				10f. ZIP CODE <b>32963</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>				15. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Sup. Judge</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Sup. Judge</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Camden County</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Rocco Palese</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret Kelly</b>				19a. INFORMANT'S NAME (Type/Print) <b>Frances M. Palese</b>	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5300 N. A1A, Unit 310, Vero Beach, FL 32963</b>				20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Calvary Cemetery</b>	
20c. LOCATION — City or Town, State <b>5/16 Cherry Hill, New Jersey</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gary L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY <b>Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227</b>	
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>INJECTION</b>	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Rayne McKell</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>				29d. DATE SIGNED (Month, Day, Year) <b>MAY 13/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Margaret M. Palese 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>								31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>	
32. REGISTRAR'S SIGNATURE <i>J. H. Anderson</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 14866

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ANDREW ALBERT PATRICK</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 12, 1995</b>		3. TIME OF DEATH <b>7:25 P. M.</b>	
4. SOCIAL SECURITY NUMBER <b>215-42-5174</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>51</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 6, 1943</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Stella Maris Hospice</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>220 W. Lorraine Avenue</b>	
10f. ZIP CODE <b>21211</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Delivery Person</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Seafood Company</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Avery G. Patrick</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Adele Kachurak</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Adele Patrick</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>220 W. Lorraine Avenue, Baltimore, Maryland 21211</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Moreland Memorial Park 5/16 Parkville, Maryland</b>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lynn B. Henss</i>		22. NAME AND ADDRESS OF FACILITY <b>Burgee-Henss Funeral Home 21211 3631 Falls Road, Baltimore, Maryland</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. COLON CANCER</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>3 mos.</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Sudden 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kendall Faulkner</i>		29c. LICENSE NUMBER <b>D25643</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/15/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>		32. REGISTRAR'S SIGNATURE <i>John A. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14867

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James W. Pumphrey, Sr.				2. DATE OF DEATH MONTH DAY YEAR May 12, 1995				3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 218-30-5383		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) April 3, 1935				8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) 151 E. Randall St.				9b. CITY, TOWN OR LOCATION OF DEATH Balto. City, Md.				9c. COUNTY OF DEATH none	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY none		10c. CITY, TOWN OR LOCATION Balto. City, Md.				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 151 E. Randall St.				10f. ZIP CODE 21230		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Fireman				16b. KIND OF BUSINESS/INDUSTRY Balto. City, Fire Dept.	
17. FATHER'S NAME (First, Middle, Last) James W. Pumphrey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emily V. Riffin					
19a. INFORMANT'S NAME (Type/Print) Mrs. Shirley A. Pumphrey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 151 E. Randall St. Balto. Md. 21230					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Memorial Pk. 5/16/95 Glen Burnie, Md.				20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Daniel A. Taylor</i>				22. NAME AND ADDRESS OF FACILITY Balto. Md. 21230 McCully Funeral Home. 130 E. Fort Ave.					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Arrhythmia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death <i>immediate</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> POA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
				28d. DESCRIBE NOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jon Forman MD</i>				29c. LICENSE NUMBER 023811	
29d. DATE SIGNED (Month, Day, Year) 5/15/95				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jon Forman, MD 1406B S. Crain Hwy STE 304 Glen Burnie Md 21061					
31. DATE FILED (Month, Day, Year) MAY 16 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME <i>Stephen Frank Pieski</i>				2. DATE OF DEATH MONTH <i>May</i> DAY <i>6</i> YEAR <i>1995</i>				3. TIME OF DEATH <i>945 PM</i>			
4. SOCIAL SECURITY NUMBER <i>225-21-3519</i>				5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>31</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>June 7, 1963</i>		8. BIRTHPLACE (State or Foreign Country) <i>England, U.K.</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Harbor Hospital Center</i>						9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>			9c. COUNTY OF DEATH <i>NA</i>		
RESIDENCE OF DECEDENT											
10a. STATE <i>Maryland</i>			10b. COUNTY <i>Anne Arundel</i>			10c. CITY, TOWN OR LOCATION <i>Crofton</i>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <i>1832 North Forest Court,</i>						10f. ZIP CODE <i>21114</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>12</i> Elementary/Secondary (9-12) <i>College (1-4 or 5+)</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Cable Installer</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Jones Intercable Co.</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Frank Pieski</i>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Olivia McKinney</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Ms. Gail J. Pieski</i>						19b. MAILING ADDRESS (Street and Number, City, State, Zip Code) <i>5 Roanoke Ct., Fredericksburg, Va. 22407</i>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) <i>Metro Crematory, Inc. 5/10/95</i>				20c. LOCATION — City or Town, State <i>Catonsville, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kevin E. Ecker</i>						22. NAME AND ADDRESS OF FACILITY <i>McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiorespiratory Arrest</i>											
DUE TO (OR AS A CONSEQUENCE OF): <i>Metastatic Hodgkins Lymphoma</i>											
DUE TO (OR AS A CONSEQUENCE OF):											
DUE TO (OR AS A CONSEQUENCE OF):											
DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joseph Anaglice MD.</i>						29c. LICENSE NUMBER <i>AS 244161436</i>			29d. DATE SIGNED (Month, Day, Year) <i>May 6 1995</i>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Joseph Anaglice MD - 3001 S. Hanover St Baltimore MD 21225</i>											
31. DATE FILED (Month, Day, Year) <i>MAY 16 1995</i>				32. REGISTRAR'S SIGNATURE <i>John A. Hurdell</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14869

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Daren Hinton Pearsall</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>12</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>11:28a</b> M	
4. SOCIAL SECURITY NUMBER <b>215-12-8323</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 19, 1922</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1212 York Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Lutherville</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Essex</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1007 Middlesex Road</b>				10f. ZIP CODE <b>21221</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3+</b> College (1-4 or 5+) <b>3+</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Post Office</b>		16b. KIND OF BUSINESS/INDUSTRY <b>n/a</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Howard J. Rearsall</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Maude Ainton</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Jessie Pearsall</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1007 Middlesex Road Baltimore Md. 21221</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory Inc. 5/13/95 Baltimore Md.</b>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>R. Terry Connelly</b>				22. NAME AND ADDRESS OF FACILITY <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md 21221</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Cardiopulmonary Arrest</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Hypovolemia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Gastrointestinal Bleeding</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Sequentially flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pt. Had Laryngectomy for Squamous Carcinoma of Larynx - was free of Disease</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <b>Physician's Office</b>					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER <b>John C. Price M.D.</b>				29c. LICENSE NUMBER <b>D-20376</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/12/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John C. Price M.D.</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <b>John C. Price</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

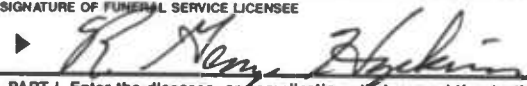





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GENEVA MAE PAULIS				2. DATE OF DEATH MONTH DAY YEAR 05 12 1995		3. TIME OF DEATH 6:00 P M	
4. SOCIAL SECURITY NUMBER 217-03-8169		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) 02-28-1917	
9a. FACILITY NAME (If not institution, give street and number) 2002 NORMAN ROAD				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE		9c. COUNTY OF DEATH ANNE ARUNDEL	
10a. STATE MARYLAND				10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION GLEN BURNIE	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 2002 NORMAN ROAD				10f. ZIP CODE 21060		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) NONE		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PACKER		16b. KIND OF BUSINESS/INDUSTRY CANDY INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) MELVIN VANBURAN CHILCOAT				18. MOTHER'S NAME (First, Middle, Maiden Surname) JOSEPHINE HYCANITH WERTH			
19a. INFORMANT'S NAME (Type/Print) C. VIRGINIA DOWNING				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2002 NORMAN ROAD GLEN BURNIE, MD 21060			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PARK 5/16/95		20c. LOCATION — City or Town, State ELKRIDGE, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W., GLEN BURNIE, MD 21061			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Amyotrophic Lateral Sclerosis DUE TO (OR AS A CONSEQUENCE OF): b. Aspiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - Hypertension - Cardiomyopathy							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Salvacion A. Dupaya		29c. LICENSE NUMBER 038912		29d. DATE SIGNED (Month, Day, Year) 05/13/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. SALVACION A. DUPAYA, 1720 CRAIN HWY., SUITE 204, GLEN BURNIE, MD 21061							
31. DATE FILED (Month, Day, Year) MAY 16 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14871

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Jerome Pollock</i>				2. DATE OF DEATH MONTH <i>MAY</i> DAY <i>05</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>7:10 A M</i>	
4. SOCIAL SECURITY NUMBER <i>217 32 1915</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>93</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Jan 21 1902</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Suburban Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Bethesda</i>		9c. COUNTY OF DEATH <i>Montgomery</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Bethesda</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>5000 Battery Lane</i>			
10f. ZIP CODE <i>20814</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>3</i> College (1-4 or 5+) <i>3</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) <i>Proprietor</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Electrical Company</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Louis Pollock</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Anna Kelman</i>			
19a. INFORMANT'S NAME (Type/print) <i>Marilyn Rudden</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9900 Harrogate Rd Bethesda, Md 20817</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>King David Mem Gdns. 5/7</i>		20c. LOCATION — City or Town, State <i>Falls Church VA</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Ives Pearson Funeral Homes Falls Church Virginia 22046</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Renal Failure</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Polycystic Kidney Disease</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>CORONARY ARTERY DISEASE</i>							Approximate interval between Onset and Death <i>5 yr</i> <i>life long</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CORONARY ARTERY DISEASE</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER <i>D32610</i>		29d. DATE SIGNED (Month, Day, Year) <i>5-5-95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 22) (Type, Print) <i>5602 Shields Rd Bethesda, Md 20817</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 16 1995</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES H. RAY SR.</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>14</b> YEAR <b>95</b>		3. TIME OF DEATH <b>10:34 P.M.</b>			
4. SOCIAL SECURITY NUMBER <b>407-16-5589</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 29, 1923</b>		8. BIRTHPLACE (State or Foreign Country) <b>Kentucky</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>357 S. FURROW STREET</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>			9c. COUNTY OF DEATH <b>N/A</b>		
10a. STATE <b>Md.</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER <b>357 S. Furrow St.</b>				10f. ZIP CODE <b>21223</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Truck Driver</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Transportation</b>				
17. FATHER'S NAME (First, Middle, Last) <b>Unobtainable</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Unobtainable</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Charles H. Ray, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>519 East Avenue, Balto., Md. 21224</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>		DATE <b>5/17</b>		20c. LOCATION — City or Town, State <b>Lansdowne, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gary L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY <b>Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227</b>					
23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Atherosclerotic cardiovascular disease</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO <b>partial</b>	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TYPE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 15, 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>									
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>									



95 14873

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Mary Elizabeth Ritzel</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 13, 1995</b>		3. TIME OF DEATH <b>2:45 A M</b>	
4. SOCIAL SECURITY NUMBER <b>185-24-9839</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>101</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 28, 1893</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Czechoslovakia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Chesapeake Health Care Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Arnold</b>	
9c. COUNTY OF DEATH <b>Anne Arundel</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>	
10c. CITY, TOWN OR LOCATION <b>Linthicum</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>105 Michael Avenue</b>	
10f. ZIP CODE <b>21090</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+) <b>Nursing Assistant</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Nursing Assistant</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Keswick Nursing Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John Walencak</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sophia</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Margaret Grove</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>105 Michael Avenue, Linthicum, Maryland 21090</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Meadowridge Memorial 5/16</b>		20c. LOCATION — City or Town, State <b>Dorsey, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James Henss Carpenter</i>				22. NAME AND ADDRESS OF FACILITY <b>Burgee-Henss Funeral Home, 21211 3631 Falls Road, Baltimore, Maryland</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Closed Head Injury from fall</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST 1. <b>Cerebrovascular Accident</b> 2. <b>Reversed from MD WPTA 5/15/95</b> 3. <b>Previous Hypertension</b> 4. <b>Previous Myocardial Infarction</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Previous Hypertension</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>4-18-95</b>		28b. TIME OF INJURY <b>4 P. M.</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED <b>Fall on the floor</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>105 Michael Ave, Linthicum</b>				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William M. Attending Doctor</i>				29c. LICENSE NUMBER <b>D21684</b>		29d. DATE SIGNED (Month, Day, Year) <b>5-15-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>CV. CYRIL M.D. 1620 CRAIN HWY #106, GLENBURNIE, MD 21061</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <i>John H. Henss</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Ethel Richardson</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>11</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>1:45 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>213-28-2045</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>91</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 15, 1904</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Sandtown Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1102 Druid Hill Ave.</b>	
10f. ZIP CODE <b>21217</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. <b>Black</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>3</b> <b>College (14 or 5+)</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Entrepreneur</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Self-employed</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Charles Scott Hancock</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Julia Anne Hancock</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Joanne Williams</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3003 Wayne Ave. Balto. Md. 21207</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place) <b>Md. National 5/17/95</b>			
20c. LOCATION — City or Town, State <b>Laurel Md.</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Joseph L. Russ</b>			
22. NAME AND ADDRESS OF FACILITY <b>Joseph L. Russ Funeral Home</b> <b>2222 W. North Ave. Balto. Md. 21216</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  a. <b>— Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>— Small derivatives when</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>— morbid obesity</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>— respiratory insufficiency</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>5/16/95</b>			
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. Abnerne W. DeBouverne</b> <b>physician</b>				29c. LICENSE NUMBER <b>D29769</b>			
29d. DATE SIGNED (Month, Day, Year) <b>5/11/95</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Marceline DeBouverne W. 516 N. Rolling</b>			
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <b>Jane Davidson-Robert</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14875

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Herbert E Robbins Sr.</u>				2. DATE OF DEATH MONTH <u>May</u> DAY <u>12th</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>9:45 A M</u>	
4. SOCIAL SECURITY NUMBER <u>410 54 5062</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>60</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Nov. 11, 1934</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Tennessee</u>				9a. FACILITY NAME (If not institution, give street and number) <u>Harbor Hospital Center</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>	
9c. COUNTY OF DEATH <u>N/A</u>				10a. STATE <u>Maryland</u>		10b. COUNTY <u>N/A</u>	
10c. CITY, TOWN OR LOCATION <u>Baltimore</u>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>3614 - 9th Street</u>	
10f. ZIP CODE <u>21225</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6th</u> College (1-4 or 5+) <u></u>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Security Guard</u>				16b. KIND OF BUSINESS/INDUSTRY <u>ABCUS Security</u>			
17. FATHER'S NAME (First, Middle, Last) <u>John Robbins</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Maggie Rossier</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Juanita Jordan</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3614 - 9th Street Baltimore, Maryland 21225</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Harness Cemetery</u>			
20c. DATE <u>5/17</u>				20d. LOCATION — City or Town, State <u>Caryville, Tennessee</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Richard E. Davis</u>				22. NAME AND ADDRESS OF FACILITY <u>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Respiratory Failure</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
<u>Chronic obstructive lung Disease</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Atherosclerotic Cardiovascular disease</u>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide							
28a. DATE OF INJURY (Month, Day, Year)							
28b. TIME OF INJURY <u>M</u>							
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
28d. DESCRIBE HOW INJURY OCCURRED							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Changjian Chen, MD</u>							
29c. LICENSE NUMBER <u>D-81174</u>							
29d. DATE SIGNED (Month, Day, Year) <u>May 12, 1995</u>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Changjian Chen, 7888 Americana Circle #101, Glen Burnie, MD 21060</u>							
31. DATE FILED (Month, Day, Year) <u>MAY 16 1995</u>							
32. REGISTRAR'S SIGNATURE <u>Juli Anderson</u>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14876

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CARL FRANKLIN RODGERS</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>10</b> , YEAR <b>1995</b>		3. TIME OF DEATH <b>2:00 P.</b>	
4. SOCIAL SECURITY NUMBER <b>218-32-3579</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>94</b> YRS.		7. DATE OF BIRTH MONTH <b>10</b> , DAY <b>19</b> , YEAR <b>1900</b>	
8. BIRTHPLACE (State or Foreign Country) <b>PENNSYLVANIA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1287 THOMPSON AVENUE</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>SEVERN</b>	
9c. COUNTY OF DEATH <b>ANNE ARUNDEL</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ANNE ARUNDEL</b>	
10c. CITY, TOWN OR LOCATION <b>SEVERN</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1287 THOMPSON AVENUE</b>	
10f. ZIP CODE <b>21144</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES <b>WW II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>N/A</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DEMOLITION ENGINEER</b>				16b. KIND OF BUSINESS/INDUSTRY <b>U.S. GOVERNMENT</b>			
17. FATHER'S NAME (First, Middle, Last) <b>(UNKNOWN)</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>(UNKNOWN)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LESTER FRANKLIN RODGERS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1287 THOMPSON AVENUE, SEVERN, MARYLAND 21144</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GRIFFITH FAMILY CEMETERY 5/13/1995</b>			
20c. LOCATION — City or Town, State <b>SEVERN, MARYLAND</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael C. Safford</i>			
22. NAME AND ADDRESS OF FACILITY <b>SINGLETON FUNERAL HOME, 1 SECOND AVENUE, SW GLEN BURNIE, MARYLAND 21061</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Respiratory Arrest</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Recent Community Acquired Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Senile Dementia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Chronic atrial fibrillation with congestive heart failure</b>			
24. IMMEDIATE CAUSE (Final disease or condition resulting in death) →				Approximate Interval Between Onset and Death			
25. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				26a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
26b. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				26c. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
29a. DATE OF INJURY (Month, Day, Year)				29b. TIME OF INJURY <b>M</b>			
29c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				29d. DESCRIBE NOW INJURY OCCURRED			
29e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29g. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29h. SIGNATURE AND TITLE OF CERTIFIER <i>William K. Hirota</i>			
29i. LICENSE NUMBER <b>D44085</b>				29j. DATE SIGNED (Month, Day, Year) <b>MAY 10, 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>WILLIAM K. HIROTA, M.D., KIMBROUGH ARMY HOSPITAL, FORT MEADE, MARYLAND</b>				31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>			
32. REGISTRAR'S SIGNATURE <i>John D. ...</i>				33. REGISTRAR'S SIGNATURE <i>John D. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14877

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Bessie Rymer</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 8, 1995</b>		3. TIME OF DEATH <b>11:55 a m</b>	
4. SOCIAL SECURITY NUMBER <b>217 34 9271</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>90 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 26, 1904</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>20 Compass Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Middle River</b>		9c. COUNTY OF DEATH <b>Baltimore County</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Middle River</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>20 Compass Road</b>				10f. ZIP CODE <b>21220</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John A. Gibson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ella G. Henry</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary E. Rymer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20 Compass Road Middle River, Maryland 21220</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gardens of Faith May 11, 1995</b>		20c. LOCATION — City or Town, State <b>Balto. Co., Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Bruzdinski Funeral Home P.A. 1407 Eastern Ave Baltimore, Maryland 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. - Carcinomatosis, abdominal</b> Due to (or as a consequence of): <b>Ca of the liver</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>							Approximate interval between Onset and Death <b>about 6 mos</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Arteriosclerosis cardio-vascular Disease &amp; congestive heart failure</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> <b>M.D.</b>				29c. LICENSE NUMBER <b>DO 1021</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/9/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>M. C. ASTRO Jr. M.D.</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>		BY REGISTRAR SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Charles A St Clair</u> CHARLES ALBERT ST. CLAIR JR.				2. DATE OF DEATH MONTH <u>MAY</u> DAY <u>13</u> YEAR <u>95</u>		3. TIME OF DEATH <u>0130</u> M	
4. SOCIAL SECURITY NUMBER <u>218-18-3222</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>69</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>06-15-1925</u>	
8. FACILITY NAME (If not institution, give street and number) <u>UNIV. OF MARYLAND HOSPITAL</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u> BALTIMORE		9c. COUNTY OF DEATH <u>N/A</u>	
10a. STATE <u>MD</u> MD				10b. COUNTY <u>ANNE ARUNDEL</u>		10c. CITY, TOWN OR LOCATION <u>Severn</u> SEVERN	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <u>827 Meadow Rd</u> 827 MEADOW ROAD		10f. ZIP CODE <u>21144</u> 21144	
10g. CITIZEN OF WHAT COUNTRY? <u>USA</u> U.S.A.				11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>WWII</u>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <u>WHITE</u>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>NONE</u>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>SECURITY</u>				16b. KIND OF BUSINESS/INDUSTRY <u>STATE OF MARYLAND</u>		17. FATHER'S NAME (First, Middle, Last) <u>CHARLES ALBERT ST. CLAIR, SR.</u>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>THELMA B. AIREY</u>				19a. INFORMANT'S NAME (Type/Print) <u>VIRGINIA R. ST. CLAIR</u>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>827 MEADOW ROAD, SEVERN, MD 21144</u>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>MARYLAND VETERANS CEMETERY</u> <u>5/17/95</u>		20c. LOCATION — City or Town, State <u>CROWNSVILLE, MD</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY <u>SINGLETON FUNERAL HOME</u> <u>1 SECOND AVE. S.W., GLEN BURNIE, MD 21061</u>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Myocardial infarction</u> a. DUE TO (OR AS A CONSEQUENCE OF): b. <u>coronary artery disease</u> c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death							
23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Patient was a 12th Sir Redo CASE</u>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				25. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u> <u>Barbara Ross</u>				29c. LICENSE NUMBER <u>D45123</u>		29d. DATE SIGNED (Month, Day, Year) <u>5/13/95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>UNIV. OF MARYLAND</u> <u>Baltimore MD</u>							
31. DATE FILED (Month, Day, Year) <u>MAY 16 1995</u> REGISTRAR'S SIGNATURE <u>[Signature]</u>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>James Scott, Sr</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>12</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>2:30 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>216 01 0285A</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JAN. 10, 1919</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SUMMIT NURSING HOME</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CATONSVILLE</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>CATONSVILLE</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>210-A winters lane</b>			
10f. ZIP CODE <b>21228</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S. OF A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HORSEMAN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>RACE TRACK</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JULIUS SCOTT</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MINNIE SCOTT</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. CAROLYN S. LE VERE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>210 A WINTERS LANE CATONSVILLE, MD. 21228</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>DRUID RIDGE CEM. 5/17/95</b>		20c. LOCATION — City or Town, State <b>PIKESVILLE, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Lewis T. Gwynn</b>				22. NAME AND ADDRESS OF FACILITY <b>LEWIS T. GWYNN FUNERAL HOME 21215 4517 PARK HEIGHTS AVE. BALTO., MD.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Metastatic Carcinoma of Esophagus</b>					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>Hepatic failure</b>					
		c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>					
		d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hx Alcohol abuse, CHF</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>B. Turakha</b>				29c. LICENSE NUMBER <b>D 36942</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/12/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>B. Turakha, MD. 1009, Frederick Rd. Catonsville, MD 21228</b>							
31. DATE OF DEATH <b>MAY 16 1995</b>		32. REGISTRAR'S SIGNATURE <b>John A. ...</b>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>TEROME STULMAN</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>10</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>0201A</b> M	
4. SOCIAL SECURITY NUMBER <b>215-32-0783</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>93</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAY 10, 1902</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3328-A CLARKS LANE</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (14 or 5+) <b>4</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>RETAIL MERCHANT</b>				16b. KIND OF BUSINESS/INDUSTRY <b>CLOTHING</b>	
17. FATHER'S NAME (First, Middle, Last) <b>MORRIS STULMAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNIE ROSENZWEIG</b>					
19a. INFORMANT'S NAME (Type/Print) <b>MRS. MARJORIE STULMAN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3328-A CLARKS LANE BALTIMORE, MD 21215</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HEBREW FRIENDSHIP 5-12-1995</b>				20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Allen S. Johnson</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>STROKE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>ASPIRATION</b> DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death <b>9 DAY</b> <b>1 Mo</b> <b>9 DAY</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION, DEMENTIA, CAROTID ARTERY DISEASE</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <i>Eric D. Skolnick MD</i>	
29c. LICENSE NUMBER <b>AS2402321-ES9847</b>								29d. DATE SIGNED (Month, Day, Year) <b>5/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SINAI HOSPITAL OF BALTIMORE</b>								<b>ERIC D. SKOLNICK</b>	
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <i>John D. Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

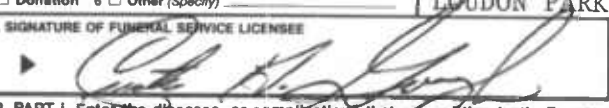
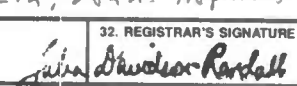
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14881

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GLADYS E. SMITH</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 12, 1995</b>		3. TIME OF DEATH <b>10:57 a m</b>	
4. SOCIAL SECURITY NUMBER <b>214-22-2389</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>SEPT. 21, 1926</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>BALTIMORE CITY</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>HARFORD</b>		10c. CITY, TOWN OR LOCATION <b>BEL AIR</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>429 RAMBLER ROAD</b>				10f. ZIP CODE <b>21015</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>12TH GRADE</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>BINDERY WORKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. GOVERNMENT PRtg OFFICE</b>	
17. FATHER'S NAME (First, Middle, Last) <b>ARCHIE SOUTHWORTH</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LILLIAN PITTS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>TOM KILLMOND</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>429 RAMBLER ROAD - BEL AIR, MARYLAND 21015</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>LOUDON PARK CEMETERY</b>		DATE <b>5/16</b>		20c. LOCATION — City or Town, State <b>BALTIMORE</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Septic Shock</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Metastatic Breast Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <b>3 months</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Noah Lechtzin, M.D. Medicine Intern</b>				29c. LICENSE NUMBER <b>M6316</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/12/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Noah Lechtzin, Johns Hopkins Hospital, Tower 110, 600 N. Wolfe, Balt, MD 21287</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 14882

Item 17, Film 723, 5/16/95, 1t

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DWIGHT F SMITH</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>12</b> , YEAR <b>1995</b>		3. TIME OF DEATH <b>10:10P</b> M	
4. SOCIAL SECURITY NUMBER <b>217-86-1876</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>32</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>AUG 17 1962</b> MD	
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTO</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3619 OAK AVE</b>				10f. ZIP CODE <b>21207</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b>		College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MODEL &amp; COMPUTER PROG</b>		16b. KIND OF BUSINESS/INDUSTRY <b>COMPUTER</b>	
17. FATHER'S NAME (First, Middle, Last) <b>JAMES F. SMITH</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LOUISE WILLIAMS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LOUISE &amp; JAMES SMITH</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3619 OAK AVE BALTO, MD 21207</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CEDAR HILL</b>		DATE <b>5/17/95</b>		20c. LOCATION — City or Town, State <b>ANNE ARUNDEL CO, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thorne A. Thompson Jr</i>				22. NAME AND ADDRESS OF FACILITY <b>MARCH F/H-WEST 4300 WABASH AVE</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>14 Kcln</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>advanced untreated 14 Kcln</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Thorne A. Thompson Jr</i>				29c. LICENSE NUMBER <b>14501</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/13/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Elliot N. Exou MD 600 W. Woke St Baltimore, MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>		32. REGISTRAR'S SIGNATURE <i>Kathleen Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DONTAE L. SMITH</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 12 1995</b>		3. TIME OF DEATH <b>2:05 A M</b>	
4. SOCIAL SECURITY NUMBER <b>216-23-0501</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>6</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT 13 1988</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD</b>				9. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL ER</b>		10. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
11. RESIDENCE OF DECEDENT				12. COUNTY OF DEATH <b>N/A</b>		13. CITY, TOWN OR LOCATION <b>BALTO</b>	
14. STATE <b>MD</b>		15. COUNTY <b>N/A</b>		16. CITY, TOWN OR LOCATION <b>BALTO</b>		17. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
18. STREET AND NUMBER <b>4133 FAIRVIEW AVE</b>				19. ZIP CODE <b>21216</b>		20. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
21. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		22. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		23. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		24. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
25. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>1ST</b> College (1-4 or 6+) <b>N/A</b>		26. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>STUDENT</b>		27. KIND OF BUSINESS/INDUSTRY <b>N/A</b>			
28. FATHER'S NAME (First, Middle, Last) <b>RONALD SMITH</b>				29. MOTHER'S NAME (First, Middle, Maiden Surname) <b>SANDRA MONTGOMERY</b>			
30. INFORMANT'S NAME (Type/Print) <b>SANDRA MONTGOMERY</b>				31. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>827 DRUID PARK LAKE DR. BALTO, MD 21216</b>			
32. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		33. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. ZION CEMETERY</b>		34. DATE <b>5/17/95</b>		35. LOCATION — City or Town, State <b>LANDSDOWNE, MD</b>	
36. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jerome A. Thompson Jr</i>				37. NAME AND ADDRESS OF FACILITY <b>MARCH F/h-WEST 4300 WABASH AVE</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. SMOKE INHALATION</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>INFECTION</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>5 12 95</b>		28b. TIME OF INJURY <b>1A M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>HOUSE</b>		28d. DESCRIBE HOW INJURY OCCURRED <b>INHALED FUMES IN HOUSE FIRE</b>					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>4133 FAIRVIEW AVE BALTIMORE</b>							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael Meyers</i>				29c. LICENSE NUMBER <b>O.C.M.E</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 13, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ms. KOREN W. 111 Penn Street, Baltimore, Maryland 2120</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 18 1995</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

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WORK INFORMATION

✓  
INFORMATION

+

✓  
HIS FOLLOWING  
INFORMATION

95 14884

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>IRVING Silverman</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>11</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>12:55A M</b>	
4. SOCIAL SECURITY NUMBER <b>396-05-5037</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7. DATE OF BIRTH (Month, Day, Year) <b>JUNE 25, 1913</b>				8. BIRTHPLACE (State or Foreign Country) <b>ILLINOIS</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>LAUREL REGIONAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>LAUREL</b>				9c. COUNTY OF DEATH <b>PRINCE GEORGE</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>PRINCE GEORGE</b>		10c. CITY, TOWN OR LOCATION <b>LAUREL</b>				10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>14509 CAMBRIDGE CIRCLE</b>				10f. ZIP CODE <b>20707</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MANAGER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>RETAIL SALES</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOSEPH SILVERMAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>IDA KRAVITZ</b>					
19a. INFORMANT'S NAME (Type/Print) <b>EVELYN SILVERMAN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14509 CAMBRIDGE CIRCLE, LAUREL, MARYLAND 20707</b>					
20a. METHOD OF DISPOSITION <b>1</b> <input type="checkbox"/> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BALTIMORE WASHINGTON CREMATORY</b>		DATE <b>5/16</b>		20c. LOCATION — City or Town, State <b>LAUREL, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Diffuse Histiocytic Lymphoma</b>  DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death <b>12 hrs.</b> <b>18 months</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>8</b> <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>8</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> <b>MD</b>				29c. LICENSE NUMBER <b>D08754</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/12/95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>THOMAS A. BENSIKBER MD 7525 GREENWAY CR. Drive Greenbelt MD</b>									
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14885

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Anne B. Salonis				2. DATE OF DEATH MONTH DAY YEAR May 13, 1995		3. TIME OF DEATH 10:30 A. M	
4. SOCIAL SECURITY NUMBER 059-09-1652		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 6, 1916	
8. BIRTHPLACE (State or Foreign Country) New York		9a. FACILITY NAME (If not institution, give street and number) 412 Music Lane		9b. CITY, TOWN OR LOCATION OF DEATH Linthicum		9c. COUNTY OF DEATH Anne Arundel	
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Glen Burnie		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1906 Oakley Road		10f. ZIP CODE 21061		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 yrs. College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Unknown Bruno				18. MOTHER'S NAME (First, Middle, Maiden Surname) Josephine Arena			
19a. INFORMANT'S NAME (Type/Print) Michelle Diddlemeyer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 412 Music Lane Linthicum, MD 21090			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Crownsville Veteran Cem. 5/16/95		20c. LOCATION — City or Town, State Crownsville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Cori L Ebaugh				22. NAME AND ADDRESS OF FACILITY Kirkley-Ruddick Funeral Home 421 Crain Hwy. S.E. Glen Burnie, MD 21061			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction b. ASCVD c. d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER William P. Jones, MD Deputy				29c. LICENSE NUMBER D06054		29d. DATE SIGNED (Month, Day, Year) 5/15/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William P. Jones, MD 695 America Ct 21035							
31. DATE FILED (Month, Day, Year) MAY 16 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FROM THE

OFFICE OF THE

SECRETARY OF THE

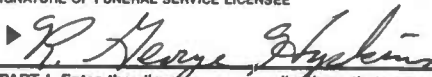
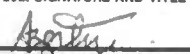
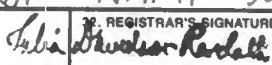
NAVY DEPARTMENT



95 14886

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HECTOR Schmidt</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>12</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>10:35 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>216-01-2846</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JANUARY 11, 1920</b>	
8. FACILITY NAME (If not institution, give street and number) <b>NORTH ARUNDEL Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Glen Burnie</b>		9c. COUNTY OF DEATH <b>ANNE ARUNDEL</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ANNE ARUNDEL</b>		10c. CITY, TOWN OR LOCATION <b>GLEN BURNIE</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>112 3rd. AVENUE SOUTH</b>				10f. ZIP CODE <b>21061</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W.W. II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>NONE</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>FOUNDRY WORKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>FOUNDRY</b>			
17. FATHER'S NAME (First, Middle, Last) <b>HARRY C. SCHMIDT</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LEILA WOLFE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>GLADYS V. SCHMIDT</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>112 3RD. AVE. SOUTH, GLEN BURNIE, MD 21061</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MEADOWRIDGE MEMORIAL PARK</b> DATE <b>5/15/1995</b>		20c. LOCATION — City or Town, State <b>ELKRIDGE, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>SINGLETON FUNERAL HOME</b> <b>1 SECOND AVE. S.W., GLEN BURNIE, MD 21061</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CONGESTIVE CARDIAC FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>CHRONIC RENAL FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death <b>12 days</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>MEDICAL HOME OFFICER</b>				29c. LICENSE NUMBER <b>D43977</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 12<sup>th</sup> '95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ANDREW DRENTI, N.A.H. 301 HOSP. DRIVE, GLEN BURNIE MD. 21061</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


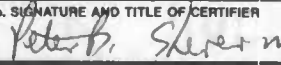
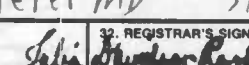
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14887

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Sofya Snitkovskaya		2. DATE OF DEATH MONTH DAY YEAR May 8, 1995		3. TIME OF DEATH 8:00pm M	
4. SOCIAL SECURITY NUMBER 213 37 8375		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 69 YRS.	
6. FACILITY NAME (If not institution, give street and number) 1400 Fenwick Lane, #912		7. DATE OF BIRTH (Month, Day, Year) Jan. 25, 1926		8. BIRTHPLACE (State or Foreign Country) Russia	
9a. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9b. COUNTY OF DEATH Montgomery			
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1400 Fenwick Lane		10f. ZIP CODE 20910	
10g. CITIZEN OF WHAT COUNTRY? Russia		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary (0-12) 12 Secondary (13-14) College (15-17) 5+ 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Motel Katzevman		18. MOTHER'S NAME (First, Middle, Maiden Surname) Leya Katzevman			
19a. INFORMANT'S NAME (Type/Print) Ikhil Snitkovskiy		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1400 Fenwick Lane, #912, Silver Spring, Md. 20910			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Judean Mem. Gdns 5/9/95		20c. LOCATION — City or Town, State Olney, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Ives-Pearson Funeral Homes Falls Church VA 22046			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Melanoma DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					Approximate interval Between Onset and Death 5 yrs.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29a. SIGNATURE AND TITLE OF CERTIFIER 		29b. LICENSE NUMBER D21910		29c. DATE SIGNED (Month, Day, Year) 5/8/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Peter B. Sherer MD 3947 Ferrara Dr. Wheaton, MD 20906					
31. DATE FILED (Month, Day, Year) MAY 16 1995		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MOLLIE THOMPSON</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>8</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>2:55P</b> M	
4. SOCIAL SECURITY NUMBER <b>229-30-9497</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-31-1910</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>MERIDIAN NURSING HOME</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>BALTO</b>	
10a. STATE <b>Md</b>				10b. COUNTY <b>BALTO</b>		10c. CITY, TOWN OR LOCATION <b>CATONSVILLE</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>115 E. MELROSE AVE.</b>				10f. ZIP CODE <b>21228</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th grade</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Domestic Worker</b>		16. KIND OF BUSINESS/INDUSTRY <b>UNKNOWN</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Westley Watson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Susie Gregory</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ALICE WATSON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6721 ALTER STREET BALTO. MD 21207</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>DRUID RIDGE CEMETERY 5/15/95</b>		20c. LOCATION — City or Town, State <b>BALTO., MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Glynn B. Scott</i>				22. NAME AND ADDRESS OF FACILITY <b>MARCH F/h-WEST 4300 WABASH AVE</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ASCVD</b>  a. DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER <b>D33847</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Robert Vissing, MD 4300 W. Charles St. Baltimore MD 21218</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ELINOR A TYDINGS</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>14<sup>th</sup></b> YEAR <b>1995</b>		3. TIME OF DEATH <b>1:10 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>236-20-6078</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>AUGUST 14, 1921</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>301 South Harbor Hospital Center Hanover St</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		8c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>ARBUTUS</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>500 Gateway Terrace</b>				10f. ZIP CODE <b>21227</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Bowling</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Edgar D. Mullen Dore</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nellie L. Smith</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Jacqueline T. Martin</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1114 Circle Dr. Arbutus, Maryland 21227</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Meadowridge Memorial Park 5/18</b>		20c. LOCATION — City or Town, State <b>Dorsey, Maryland</b>		20d. DATE <b>5/18</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>AMBROSE FUNERAL HOME OF LANSDOWNE 2719 HAMMONDS FERRY RD. BALTO, MD. 21227</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>HYPOXIC ENCEPHALOPATHY</b>				Approximate Interval Between Onset and Death <b>30 min</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>STATUS POST CARDIO PULMONARY RESUSCITATION</b>					
		c. <b>EMPHYSEMA</b>					
		d. <b></b>					
		e. <b></b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Thomas J. Kotykatel INTERN.</b>				29c. LICENSE NUMBER <b>52441614-21</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 14<sup>th</sup> 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>THOMAS J. KOTYKATEL HARBOR HOSPITAL CENTER 3002 S. HANOVER STREET, BALTIMORE MD 21225</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Petrese Thompson</b>				2. DATE OF DEATH MONTH <b>05</b> DAY <b>12</b> YEAR <b>95</b>		3. TIME OF DEATH <b>9:50 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>080-42-3168</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>44</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>03/27/51</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Alabama</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Horizon Specialty Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>Balto City</b>				10a. STATE <b>Md</b>			
10b. COUNTY <b>NA</b>				10c. CITY, TOWN OR LOCATION <b>Baltimore</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>3607 Fernhill Avenue</b>			
10f. ZIP CODE <b>21215</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th grade</b> College (1-4 or 5+) <b>NA</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Binder</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Port City Press</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Willie Shephard</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Minnie Burroughs</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Laverne Shephard</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3607 Fernhill Avenue Balto, Md 21215</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Ding Mem Park</b>		20c. LOCATION — City or Town, State <b>Randallstown, Md</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Sala March</b>				22. NAME AND ADDRESS OF FACILITY <b>March F.H. West 4300 Wabash Ave Balto, Md 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acquired Immunodeficiency Syndrome</b> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death <b>2 YEARS</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>MD</b>				29c. LICENSE NUMBER <b>D38675</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/13/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOEL MESHULAM 1147 SHANOVER ST BALTIMORE MD 21230</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>		32. REGISTRAR'S SIGNATURE <b>Julia Anderson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. *Handwritten text, possibly a signature or date.*

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ERMA VIRGINIA <del>THEI</del> THIESS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 11 1995</b>		3. TIME OF DEATH <b>2:25 A M</b>	
4. SOCIAL SECURITY NUMBER <b>217 09 0411</b>		5. SEX <b>M 2 X F</b>	6. AGE (In yrs. last birthday) <b>82 YRS.</b>	7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 14, 1912</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Meridian Nursing Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Catonsville</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <b>1 YES 2 X NO</b>	
10e. STREET AND NUMBER <b>10 W. 3rd Avenue</b>				10f. ZIP CODE <b>21225</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <b>3 X Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 X NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 X NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 6th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Home Maker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Smith</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Bush</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Erma Riser</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6462 Lacrosse Lane Glen Burnie, Maryland 21061</b>			
20a. METHOD OF DISPOSITION <b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Glen Haven Memorial Park 5/15</b>		20c. LOCATION — City or Town, State <b>Glen Burnie, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jerome J. Gonce</i>				22. NAME AND ADDRESS OF FACILITY <b>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Myocardial Infarction</b> <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> <b>Hypertension</b>							Approximate Interval Between Onset and Death <b>8 Weeks</b> <b>Years.</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimer's Disease</b>							24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 X NO</b>
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 X NO</b>							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 X NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>					
27. MANNER OF DEATH <b>1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>N. B. Vellanki</i>				29c. LICENSE NUMBER <b>D 30469</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 12 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>9055, Chevrolet Drive, #Suite 100, Ellicott City, MD 21042. (Dr. N. B. Vellanki)</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>		32. REGISTRAR'S SIGNATURE <i>John A. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14892

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Sylvia Thompson</i>				2. DATE OF DEATH MONTH <i>May</i> DAY <i>10</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>9:55 P.M.</i>	
4. SOCIAL SECURITY NUMBER <i>212-46-2457</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>48</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>1/29/47</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>				9a. FACILITY NAME (If not institution, give street and number) <i>5000 Cordelia Avenue</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>	
9c. COUNTY OF DEATH <i>N/A</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>N/A</i>	
10c. CITY, TOWN OR LOCATION <i>Baltimore</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>5000 Cordelia Avenue</i>	
10f. ZIP CODE <i>21215</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>10</i> Elementary/Secondary (9-12) <i>0</i> College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Domestic</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Outside Home</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Sylvester Parker</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Natlee Wilson</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Natlee Parker</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3800 W. Belvedere Ave. Arto Balto. Md. 21215</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <i>Mr. Lion 5/15/95</i>		20c. LOCATION — City or Town, State <i>Lansdowne, Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph L. Russ</i>				22. NAME AND ADDRESS OF FACILITY <i>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>disseminated MAI</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>AIDS</i> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate interval between Onset and Death <i>months</i> <i>3 years</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ _____							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ellen M Okun, MD</i>				29c. LICENSE NUMBER <i>D36828</i>		29d. DATE SIGNED (Month, Day, Year) <i>5/12/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Ellen M Okun 2435 W. Belvedere Suite 22 Balto md 21215</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 16 1995</i>				32. REGISTRAR'S SIGNATURE <i>John R. Baker</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14893

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Edward Anthony Tutas</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 15, 1995</b>		3. TIME OF DEATH <b>6:50a</b> M	
4. SOCIAL SECURITY NUMBER <b>027-18-7247</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 21, 1925</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Massachusetts</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1836 Ralston Place</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Crofton</b>	
9c. COUNTY OF DEATH <b>Anne Arundel</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>	
10c. CITY, TOWN OR LOCATION <b>Crofton</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1836 Ralston Place</b>	
10f. ZIP CODE <b>21114</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Electronics Engineer</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Electronics</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Anthony Tutas</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Wanda Hamerska</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ingrid Tutas</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1836 Ralston Place, Crofton, MD 21114</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Maryland Veterans Cem. 5/17</b>			
20c. LOCATION — City or Town, State <b>Crownsville, MD</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sharon H. Handcock</i>			
22. NAME AND ADDRESS OF FACILITY <b>Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory/Cardiac arrest</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>End stage heart failure.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Insulin dependent Diabetes mellitus.</b> DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>gout.</b>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>May 15, 1995</b>			
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John H. Handcock</i>				29c. LICENSE NUMBER <b>D25134</b>			
29d. DATE SIGNED (Month, Day, Year) <b>5/15/95</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>1684 VILLAGE GREEN, CROFTON MD 21114</b>			
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <i>John H. Handcock</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 14894

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HENRY TOLES, JR.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 6, 1995</b>		3. TIME OF DEATH <b>7:15P M</b>	
4. SOCIAL SECURITY NUMBER <b>213-68-9833</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>38</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JULY 8, 1956</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1427 N. AISQUITH ST.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE,</b>	
9c. COUNTY OF DEATH <b>N/A</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>N/A</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1427 N. AISQUITH ST.</b>	
10f. ZIP CODE <b>21202</b>				10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>X</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b> College (1-4 or 5+) <b>N/A</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>OFFICE CLERK</b>		16b. KIND OF BUSINESS/INDUSTRY <b>MONUMENTAL LIFE INS. CO.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>HENRY TOLES, SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>FANNIE WILLIAMS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>FANNIE TOLES</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1426 N. AISQUITH ST. BALTO, MD. 21202</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. ZION CEM. 5-13-95</b>		20c. LOCATION — City or Town, State <b>BALTO, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin B. Scruggs, Jr.</i>				22. NAME AND ADDRESS OF FACILITY <b>CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ACQUIRED IMMUNODEFICIENCY SYNDROME</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>b. HIV INFECTION</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard A. O'Malley MD</i>				29c. LICENSE NUMBER <b>D45432</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 9, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RICHARD A. O'MALLEY MD. MERCY MEDICAL CENTER 301 ST PAUL PLACE BALTIMORE 21202</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <i>John H. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14895

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) June H. Van Leeuwen				2. DATE OF DEATH MONTH DAY YEAR May 13, 1995				3. TIME OF DEATH 1600 M	
4. SOCIAL SECURITY NUMBER 048-38-2483		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 99 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jun. 14, 1895		8. BIRTHPLACE (State or Foreign Country) Iowa	
9a. FACILITY NAME (If not institution, give street and number) Meridian-Spa Creek				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis				9c. COUNTY OF DEATH Anne Arundel	
10a. STATE MD				10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Annapolis		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 35 MilkShake Lane				10f. ZIP CODE 21403		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Lee Edward Hinman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Edward Popelka					
19a. INFORMANT'S NAME (Type/Print) Jean Lee Eareckson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3114 Landfall Lane, Annapolis, MD 21403					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory		20c. DATE 5/15		20d. LOCATION — City or Town, State Baltimore, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas A. Hardesty</i>				22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis MD 21401					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>STROKE</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): <b>CEREBROVASCULAR DISEASE</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate interval Between Onset and Death <b>5 DAYS</b> <b>YRS</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER A23142		29d. DATE SIGNED (Month, Day, Year) 5/15/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S. J. KRIMINS, M.D. 980 BEECHER RD. ANNAPOLIS MD									
31. DATE FILED (Month, Day, Year) MAY 16 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14896

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GEORGE WASHINGTON VOIT, SR.</b>				2. DATE OF DEATH MONTH <b>05</b> DAY <b>12</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>11:55 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>213-05-5391</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>99</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-9-1895</b>	
8. FACILITY NAME (If not institution, give street and number) <b>KNOLLWOOD MANOR NURSING HOME</b>				9. CITY, TOWN OR LOCATION OF DEATH <b>MILLERSVILLE</b>		10. COUNTY OF DEATH <b>ANNE ARUNDEL</b>	
11. STATE <b>MD</b>		12. COUNTY <b>ANNE ARUNDEL</b>		13. CITY, TOWN OR LOCATION <b>GLEN BURNIE</b>		14. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
15. STREET AND NUMBER <b>112 LINWOOD AVE.</b>				16. ZIP CODE <b>21061</b>		17. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
18. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		19. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWI</b>		20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		21. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
22. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>UNKNOWN</b> College (1-4 or 5+) <b>UNKNOWN</b>		23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ASSEMBLY LINE WORKER</b>		24. KIND OF BUSINESS/INDUSTRY <b>ELECTRONICS</b>			
25. FATHER'S NAME (First, Middle, Last) <b>LEOPOLD VOIT</b>				26. MOTHER'S NAME (First, Middle, Maiden Surname) <b>WILHELMINE SCHOEN</b>			
27. INFORMANT'S NAME (Type/Print) <b>GEORGE W. VOIT, JR.</b>				28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>206 FOX TRAIL, WINCHESTER, VA 22602</b>			
29. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BALTIMORE NATIONAL CEMETERY 5/16/95 BALTIMORE, MD</b>		31. DATE <b>5/16/95</b>		32. LOCATION — City or Town, State <b>MD</b>	
33. SIGNATURE OF FUNERAL SERVICE LICENSEE 				34. NAME AND ADDRESS OF FACILITY <b>SINGLETON FUNERAL HOME 1 SECOND AVE. S.W., GLEN BURNIE, MD 21061</b>			
35. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b> Approximate interval Between Onset and Death <b>48 hrs</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
36. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DEHYDRATION</b> <b>DEMENTIA</b>							
37. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				38. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		39. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
40. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		41. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
42. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		43. DATE OF INJURY (Month, Day, Year)		44. TIME OF INJURY <b>M</b>		45. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
46. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				47. DESCRIBE NOW INJURY OCCURRED			
48. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
49. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
50. SIGNATURE AND TITLE OF CERTIFIER Attending				51. LICENSE NUMBER <b>D 21776</b>		52. DATE SIGNED (Month, Day, Year) <b>5/15/95</b>	
53. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SURYA MURRAY MD 203 E Patapsco Av Baltimore MD 21225</b>							
54. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				55. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14897

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>SARAH (SALLY) NEALE WATSON</b>				2. DATE OF DEATH MONTH <b>05</b> DAY <b>13</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>8:40 A<sup>M</sup></b>	
4. SOCIAL SECURITY NUMBER <b>559-36-2411</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 19, 1908</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>PICKERSGILL RETIREMENT COMMUNITY</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Towson</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>615 Chestnut Ave.</b>	
10f. ZIP CODE <b>21204</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 yrs</b> College (1-4 or 5+) <b>Lab Tech</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Lab Tech</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Medical</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Dr. Leonard Ernest Neale</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sarah Sterett</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Neale Howard Watson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4517 Lower Beckleysville Rd. Hamstead, Md. 21074</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley 5-17</b>		20c. LOCATION — City or Town, State <b>Timonium, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute cerebrovascular Accident</b> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death: <b>&lt; 1 hour</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D25205</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/15/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>W. A. R. J. G B M C</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b> REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14898

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>IDA WRIGHT</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>10</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>0422</b> M	
4. SOCIAL SECURITY NUMBER <b>214-01-9893</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JULY 7, 1908</b>	
8. BIRTHPLACE (State or Foreign Country) <b>RUSSIA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>PIKESVILLE NURSING HOME</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>PIKESVILLE</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>605 KAHN DRIVE</b>			
10f. ZIP CODE <b>21208</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 6+) <b>HOUSEWIFE</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>AT HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>SOLOMON WRIGHT</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LOTTIE UNKNOWN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MR. IRVIN WRIGHT</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>605 KAHN DRIVE BALTIMORE, MD 21208</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MOSES MONTEFIORE</b>		DATE <b>5-12-1995</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ellenue Levinson</b>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>UPPER GI BLEED</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>WIDELY METASTATIC CANCER</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>OF UNKNOWN PRIMARY</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>SMALL BOWEL OBSTRUCTION</b> Approximate Interval Between Onset and Death <b>DAYS</b> <b>Mo-YR</b> <b>DAYS</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>INSULIN DEPENDENT DIABETES, HYPOTHYROID, A-FIB, S/P FRONTAL LOBECTOMY</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Eric D. Skolnick MD</b>				29c. LICENSE NUMBER <b>AS-2402321-ES9847</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/16/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ERIC D. SKOLNICK SINAI HOSPITAL OF BALTIMORE</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>VALERIE FENTRESS WHITE-FOWLKES</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>13</b> YEAR <b>95</b>		3. TIME OF DEATH <b>02:33 A M</b>	
4. SOCIAL SECURITY NUMBER <b>219-19-6699</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>SEPT. 22, 1920</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		8c. COUNTY OF DEATH <b>n/a</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>n/a</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>822 IVANDALE AVENUE</b>				10f. ZIP CODE <b>21236 21136</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 TH</b> College (1-4 or 5+) <b>- some</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>TEACHER</b>		15b. KIND OF BUSINESS/INDUSTRY <b>BALTIMORE CITY PUBLIC SCHOOL</b>			
17. FATHER'S NAME (First, Middle, Last) <b>CLARENCE R. WHITE SR.</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LOUISE FRANCIS GAINES</b>			
19a. INFORMANT'S NAME (Type/Print) <b>GREGORY WHITE FOWLKES</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>822 IVANDALE AVENUE, BALTIMORE, MD 21136</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>MT. CALVARY CEMETERY</b>		DATE <b>54 5-18</b>		20c. LOCATION — City or Town, State <b>ANNE ARUNDEL CO, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>See V. Holland</i>				22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FH.-1101 E. NORTH AVENUE</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. SEVERE LACTIC ACIDOSIS</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. HYPOTENSION, SEIZURES</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>							Approximate Interval Between Onset and Death <b>ONE DAY</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <b>TO BE PERFORMED</b>	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>D. JILLAPALLI MD</b>				29c. LICENSE NUMBER <b>P 08238</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 13, 95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>D JILLAPALLI, GOOD SAMARITAN HOSPITAL, BALTIMORE MD 21239</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <i>Richard</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95-2738-005

blh

95 14900

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Dajonna LAURA White				2. DATE OF DEATH MONTH DAY YEAR May 11 1995		3. TIME OF DEATH 0915 M	
4. SOCIAL SECURITY NUMBER 218-43-0676		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS 2 14		7. DATE OF BIRTH (Month, Day, Year) FEB. 24, 1995	
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rossville		9c. COUNTY OF DEATH Baltimore	
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION ESSEX		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1606 RICKENBACKER ROAD APT. B				10f. ZIP CODE 21221		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) none College (1-4 or 5+) -		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BABY		16b. KIND OF BUSINESS/INDUSTRY none			
17. FATHER'S NAME (First, Middle, Last) ANTONIO WHITE				18. MOTHER'S NAME (First, Middle, Maiden Surname) MICHELE HENRY			
19a. INFORMANT'S NAME (Type/Print) DORA HENRY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5662 WHITBY ROAD, BALTIMORE, MD 21206			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) VOSHALL MEMORIAL GARDENS 5-18		20c. LOCATION — City or Town, State DUNDALK, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>See V. Holland</i>				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sudden Infant Death Syndrome DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> 1 Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chute m</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) May 11 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) MAY 1 6 1995		32. REGISTRAR'S SIGNATURE <i>John A. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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Dr. SABA Siddiqui  
(410)-549-2890

95 14901

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CAROLYN WORRELL</b>				2. DATE OF DEATH MONTH DAY YEAR <b>05 14 95</b>		3. TIME OF DEATH <b>5:50 A</b> M	
4. SOCIAL SECURITY NUMBER <b>214-54-5210</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>46</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>6-10-48</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Baltimore</b>				9a. FACILITY NAME (If not institution, give street and number) <b>IRVINGTON KNOLLS CARE CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>22 South Athol St.</b>	
9c. COUNTY OF DEATH <b>Baltimore City</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>N/A</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1355 N. CAREY STREET 1st Floor</b>	
10f. ZIP CODE <b>21217</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>BEAUTICIAN</b>	
16b. KIND OF BUSINESS/INDUSTRY <b>COSMETOLOGY</b>		17. FATHER'S NAME (First, Middle, Last) <b>JAMES CARTER</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>VIOLA JENNINGS</b>		19a. INFORMANT'S NAME (Type/Print) <b>LOUIS R. WORRELL</b>	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1355 N. Carey St. 1st Flr. Baltimore, Maryland 21217</b>		20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>KING MEMORIAL PARK 5/18 WOODLAWN, MARYLAND</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		22. NAME AND ADDRESS OF FACILITY <b>WILLIAM C. BROWN COMMUNITY F/H 1206 W. North Avenue</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hepatic Failure</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  a. <b>Hepatic Encephalopathy</b> b. <b>Hepatic Cirrhosis</b> c. <b>Alcoholic Hepatitis</b> d. <b>Alcoholic Hepatitis</b>  Approximate Interval Between Onset and Death <b>2 wks</b> <b>2 wks</b> <b>few yrs</b> <b>Several yrs</b>		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Saba Siddiqui MD</b>		29c. LICENSE NUMBER <b>041496</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/14/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SABA SIDDIQUI P.O. BOX 1313 Sykesville MD 21784</b>		31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Blackman, J. W. 1901





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ELSE Walman</b>				2. DATE OF DEATH MAY 10 1995 11:30 P M				3. TIME OF DEATH					
4. SOCIAL SECURITY NUMBER <b>217183685</b>				5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH 10-25-12		8. BIRTHPLACE (State or Foreign Country) <b>AUSTRIA</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH <b>N/A</b>			
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>BALTIMORE</b>				10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2812 LAURELWOOD COURT</b>						10f. ZIP CODE <b>21209</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>HOUSEWIFE</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>				16b. KIND OF BUSINESS/INDUSTRY <b>AT HOME</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Narzissenfeld</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>SHANDEL HAFTEL</b>							
19a. INFORMANT'S NAME (Type/Print) <b>MR. JACOB WALMAN</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2812 LAURELWOOD COURT BALTIMORE, MD 21209</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or place of interment) <b>BNAT ISRAEL</b>				20c. LOCATION — City or Town, State <b>5-12-1995 BALTIMORE, MD</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Glenore Swanson</b>						22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE MD 21215</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Thrombocytopenia</b>													
DUE TO (OR AS A CONSEQUENCE OF): <b>VASCULITIS</b>													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Melinda Greenfield D.O.</b>						29c. LICENSE NUMBER <b>AS2402321 MG 9824</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 10, 1995</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Melinda Greenfield SINAI HOSPITAL</b>													
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14903

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Lucy Alice Watson</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>15</b> , YEAR <b>1995</b>		3. TIME OF DEATH <b>3:45 A M</b>	
4. SOCIAL SECURITY NUMBER <b>235-30-0390</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>FEB. 24, 1924</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Meridian Nursing Center in Catonsville</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Catonsville</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Howard</b>		10c. CITY, TOWN OR LOCATION <b>Columbia</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>9332 Pirates Cove</b>				10f. ZIP CODE <b>21046</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>8th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Gus Smith</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ida Hyde</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Thomas O. Watson, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9332 Pirates Cove, Columbia, MD 21046</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 05/15/95</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Dawn F. McDonald</b>				22. NAME AND ADDRESS OF FACILITY <b>Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>End Stage Alzheimer's Disease</b>					
		b. <b>Possible Aspiration Pneumonia</b>					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. <b>Due to (OR AS A CONSEQUENCE OF):</b>					
		d. <b>Due to (OR AS A CONSEQUENCE OF):</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Edmund Tkaczuk, M.D.</b>				29c. LICENSE NUMBER <b>D34151</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 15, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Edmund Tkaczuk, M.D. 405 Frederick Rd. Suite 100 Catonsville, MD 21228</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>		32. REGISTRAR'S SIGNATURE <b>J. A. [Signature]</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.




95 14904

ITEMS : 17. &amp; 18. PER F.H. FILM G-723 5/16/95 t.t

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Stella SADIE Wehl</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>14</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>1:00 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>089-22-2644</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>APRIL 7, 1908</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>LAUREL REGIONAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>LAUREL</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGE</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>PRINCE GEORGE</b>		10c. CITY, TOWN OR LOCATION <b>LAUREL</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>13400 KIAMA COURT</b>			
10f. ZIP CODE <b>20708</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		15b. KIND OF BUSINESS/INDUSTRY <b>HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>FRANCIS WISNIEWSKI KONSTANTY WISNIEWSKI</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>FRANCES WITKOWSKI FRANCES WITKOWSKI</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MARTIN J. LEPKOWSKI</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13400 KIAMA COURT, LAUREL, MARYLAND 20708</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BALTIMORE-WASHINGTON CREMATORY 5/16</b>		20c. LOCATION — City or Town, State <b>LAUREL, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Coronary artery disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>Hours</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive Heart Failure</b> <b>Pneumonia</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Jenny Y. May MD</b>				29c. LICENSE NUMBER <b>D43260</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 14, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Spec. Form) <b>Jenny Y. May MD 14333 Laurel Bowtie Rd # 307 Laurel MD 20708</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE <b>Jane Shuler Karball</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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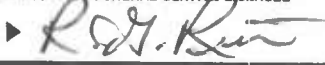
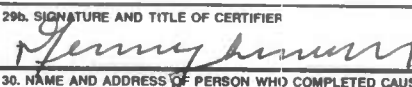

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14905

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GEORGE WARREN WAGNER, JR.</b>				2. DATE OF DEATH MONTH <b>05</b> DAY <b>11</b> YEAR <b>95</b>		3. TIME OF DEATH <b>8:35 A.</b> M	
4. SOCIAL SECURITY NUMBER <b>212-38-8211</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>03-31-33</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>116 WEST UNIVERSITY PARKWAY</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>N/A</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>116 WEST UNIVERSITY PARKWAY</b>			
10f. ZIP CODE <b>21210</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1955 - 1958</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4 YEARS</b> College (1-4 or 5+) <b>4 YEARS</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MANUFACTURER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>BOX COMPANY</b>	
17. FATHER'S NAME (First, Middle, Last) <b>GEORGE WARREN WAGNER, SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>JOSEPHINE KING</b>			
19a. INFORMANT'S NAME (Type/Print) <b>EVELYN L. WAGNER (WIFE)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5000 BROADMOORE RD., BALTIMORE, MD. 21212</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GREEN MOUNT CREMATORY 5-12 BALTO., MD., 21202</b>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>HENRY W. JENKINS &amp; SONS 4905 YORK ROAD, BALTIMORE, MD. 21212</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>GASTRIC HEMORRHAGE</b>							
b. <b>ESOPHAGEAL VARICES</b>							
c. <b>CHRONIC ALCOHOLISM</b>							
d. <b>10 MIN.</b>							
e. <b>2 YRS.</b>							
f. <b>10 YRS.</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence 5 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28g. DATE SIGNED (Month, Day, Year) <b>05-11-95</b>	
29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D 33400</b>		29d. DATE SIGNED (Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>IREDELL W. IGLEART III M.D., 500 W. UNIVERSITY PKWY., BALTO., MD., 21210</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14906

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Paul Wilton Zeger</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>13</b> , YEAR <b>1995</b>		3. TIME OF DEATH YEAR <b>3:50</b> P <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>186 30 5507</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>55</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 13, 1939</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Penna.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1929 Eloise Lane</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Edgewood</b>	
9c. COUNTY OF DEATH <b>Harford</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>	
10c. CITY, TOWN OR LOCATION <b>Edgewood</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1929 Eloise Lane</b>	
10f. ZIP CODE <b>21040</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>Carpenter</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Carpenter</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Construction</b>	
17. FATHER'S NAME (First, Middle, Last) <b>George Zeger</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Venie Wiser</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Shirley Zeger</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1929 Eloise Lane Edgewood, Maryland 21040</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HOLLY Hill Mem. Gardens 5/16/95</b>		20c. LOCATION — City or Town, State <b>Baltimore County, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Bruzdinski Funeral Home P.A. 1407 Eastern Ave. Baltimore, Maryland 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Hepatic Failure</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Hepatitis B</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death: <b>20 Years</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hepatic Encephalopathy</b> <b>Concomitant</b> <b>Blurred Vision</b> <b>Acute</b>							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Kenneth B Kochman</b>			
29c. LICENSE NUMBER <b>045421</b>				29d. DATE SIGNED (Month, Day, Year) <b>5/15/95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Kenneth B Kochman 1914 Belair Rd Taketon MD 21047</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


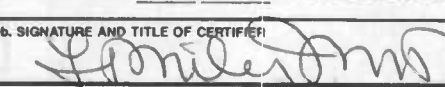
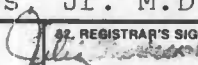
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text, possibly a signature or date, located near the bottom center of the page.

95 14907

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>PEARL THELMA ADKINS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APR. 29, 1995</b>		3. TIME OF DEATH <b>7:15 A M</b>	
4. SOCIAL SECURITY NUMBER <b>213-10-9718</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>SEPT. 18, 1909</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not Institution, give street and number) <b>Egle Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Lonaconing</b>	
9c. COUNTY OF DEATH <b>Allegany</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Allegany</b>	
10c. CITY, TOWN OR LOCATION <b>Frostburg</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>19 Mill Syreet</b>	
10f. ZIP CODE <b>21532</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John Fresh</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Martha Alexander</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Karen L. Stair</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>105 Victoria Lane, Frostburg, Md. 21532</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Frostburg Memorial Park</b>		20c. LOCATION — City or Town, State <b>5/1 Frostburg, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>57 Frost Ave. Durst Funeral Home, Frostburg, Md. 21532</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CVA</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>ARTERIOSCLEROSIS</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D07004</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 1, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Leslie R. Miles, Jr. M.D. 57 Jackson Street, Lonaconing, MD 21539</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 03 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14908

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Louise Amodei</b>				2. DATE OF DEATH MONTH <b>04</b> DAY <b>24</b> YEAR <b>95</b>		3. TIME OF DEATH <b>6:00 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>223 48 9601</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>89</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 3, 1905</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Anne Arundel Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Crofton</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1650 Dryden Way</b>				10f. ZIP CODE <b>21114</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>No</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: <b>No</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>6</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Guidance Counselor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>P.G. Co. Schools</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Joseph LaSala</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Benedetta Vache</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Frank V. Amodei</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1650 Dryden Way Crofton Maryland 21114</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		20c. LOCATION — City or Town, State <b>Alexandria Virginia</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert E. Evans Pres</b>				22. NAME AND ADDRESS OF FACILITY <b>Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Gastrointestinal Bleeding</b>					Approximate Interval Between Onset and Death <b>2 weeks</b>
		b. <b>Giant duodenal ulcer</b>					<b>2 weeks</b>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. _____					
		d. _____					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Recent myocardial infarction</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>None</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Caryn Berkowitz, MD</b>		29c. LICENSE NUMBER <b>D46788-MD.</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/24/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Caryn M. Berkowitz, MD 621 Ridgely Ave, Suite 201, Annapolis, MD 21401</b>							
31. DATE FILED (Month, Day, Year) <b>APR 25 1995</b>		32. REGISTRAR'S SIGNATURE <b>John A. Anderson</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14909

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GEORGE T. BLAUVELT, III				2. DATE OF DEATH MONTH DAY YEAR APRIL 24, 1995		3. TIME OF DEATH 6:30 A M	
4. SOCIAL SECURITY NUMBER 137-46-4870		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 44 YRS.	7. DATE OF BIRTH (Month, Day, Year) February 15, 1951		8. BIRTHPLACE (State or Foreign Country) New Jersey	
9a. FACILITY NAME (If not institution, give street and number) Prince Georges Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince Georges	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Landover Hills		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 6916 Barton Road				10f. ZIP CODE 20784		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Accountant-Auditor		16b. KIND OF BUSINESS/INDUSTRY Treasury Department			
17. FATHER'S NAME (First, Middle, Last) George T. Blauvelt, Jr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Josephine Bianco			
19a. INFORMANT'S NAME (Type/Print) George T. Blauvelt, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222 Elm Street, Elmwood Park, NJ 07407			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Calvary Cemetery		DATE 4/28/95		20c. LOCATION — City or Town, State Paterson, NJ	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen J. Smith</i>				22. NAME AND ADDRESS OF FACILITY Rendon/Hale Lanham Funeral Home 9013 Annapolis Road, Lanham, MD 20706			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. AIDS							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hepatitis - pneumonia - Dehydration							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sam Tellawi</i>		29c. LICENSE NUMBER D34274		29d. DATE SIGNED (Month, Day, Year) 4-24-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sam Tellawi, M.D., 4000 Mitchellville Road, Bowie, MD							
31. DATE FILED (Month, Day, Year) APR 25 1995		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Robert</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Amended #5, 5/4/95, N.L.S., Allegany Co.

95 14910

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CLYDE OSCAR BEEMAN</b>				2. DATE OF DEATH MONTH <b>MAY</b> DAY <b>2</b> , YEAR <b>1995</b>		3. TIME OF DEATH <b>1:15 P M</b>			
4. SOCIAL SECURITY NUMBER <b>217-30-1791</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>61</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 5, 1933</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not Institution, give street and number) <b>Sacred Heart Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>			9c. COUNTY OF DEATH <b>Allegany</b>		
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Frostburg</b>			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER <b>66 N. Water Street</b>				10f. ZIP CODE <b>21532</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Tire Builder</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Auto Tires</b>				
17. FATHER'S NAME (First, Middle, Last) <b>Oscar Beeman</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Flossie Broadwater</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Jean Beeman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>66 N. Water Street Frostburg, Maryland 21532</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Laurel Hill Cemetery May 5, 95</b>		DATE <b>May 5, 95</b>		20c. LOCATION — City or Town, State <b>Moscow, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John R. Durst</i>				22. NAME AND ADDRESS OF FACILITY <b>Durst Funeral Home 57 Frost Avenue Frostburg, Md. 21532</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lymphoma with metastasis to meninges &amp; central nervous system</b> Approximate Interval Between Onset and Death <b>8 months</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension Diabetes mellitus Cancer Colon</b>									
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>SL Sandhir M.D.</b>				29c. LICENSE NUMBER <b>D14464</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 3rd. 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. SIKANDER SANDHIR, M.D., 48 TARN TERRACE, FROSTBURG, MD 21532</b>									
31. DATE FILED (Month, Day, Year) <b>MAY 04 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					



95-2493-035

blh

ITEMS: 23 PART I, 27, 28a.-f, PER MEO FILM G-723 5/12/95 t.t

95 14911

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Carlton Bennett III</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 28 1995</b>		3. TIME OF DEATH <b>1049 A</b>	
4. SOCIAL SECURITY NUMBER <b>220-84-4340</b>		5. SEX <b>XX M 2 F</b>	6. AGE (In yrs. last birthday) <b>24</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 17, 1970</b>	8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>Governor Grason Drive 1/8 mi. from Bennett Point Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Queenstown</b>		9c. COUNTY OF DEATH <b>Queene Anne</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Queen Anne's</b>		10c. CITY, TOWN OR LOCATION <b>Grasonville</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4405 Main Street</b>				10f. ZIP CODE <b>21638</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (13-16 or 17+) <b>College (13-16 or 17+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Lawn Service</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Anthony's Lawn Service</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Carlton Bennett, Jr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret Costin</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Carlton Bennett, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P. O. Box 332 Grasonville, Md. 21638</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Stevensville Cemetery May 2, 1995</b>		20c. LOCATION — City or Town, State <b>Stevensville, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Thomas H. Helfenbein</b>				22. NAME AND ADDRESS OF FACILITY <b>Tom Helfenbein Funeral Homes, P.A. 106 Shamrock Rd., Chester, Md. 21619</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>COCAINE INTOXICATION</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>at scene in vehicle</b>					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>FOUND ON 4/27/95</b>	28b. TIME OF INJURY <b>10:00 A</b>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED <b>UNKNOWN</b>		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>FOUND AT HOME</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>1322 PERRY'S CORNER RD. GRASONVILLE, MARYLAND</b>					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TYPE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 29 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>David R. Fowler 111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 12 1995</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14912

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Blackburn, Ronald W.</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 27 1995</i>		3. TIME OF DEATH HOURS MINUTES <i>11 44 P. M.</i>	
4. SOCIAL SECURITY NUMBER <i>213-24-5112</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>66</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Jan. 13, 1929</i>	
8. BIRTHPLACE (State or Foreign Country) <i>WV</i>				9a. CITY, TOWN OR LOCATION OF DEATH <i>Cumberland</i>		9c. COUNTY OF DEATH <i>Allegany</i>	
9b. FACILITY NAME (If not institution, give street and number) <i>Memorial Hospital</i>				10a. STATE <i>WV</i>			
10b. COUNTY <i>Hampshire</i>				10c. CITY, TOWN OR LOCATION <i>Greenspring</i>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>PO Box 101</i>			
10f. ZIP CODE <i>26722</i>				10g. CITIZEN OF WHAT COUNTRY? <i>US</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>NA</i> College (1-4 or 5+) <i>College</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Park Maintenance</i>		16b. KIND OF BUSINESS/INDUSTRY <i>City parks</i>			
17. FATHER'S NAME (First, Middle, Last) <i>William L. Blackburn</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Edress C. Bissett</i>			
19a. INFORMANT'S NAME (Type/Print) <i>James H. Kinlein</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>HC 71, Box 152A, Augusta, WV 26704</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Omps Cremation Service April 30, 1995</i>		20c. LOCATION — City or Town, State <i>Winchester, VA</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Shaffer Funeral Home, Inc.</i>				22. NAME AND ADDRESS OF FACILITY <i>230 E. Main St., Romney, WV 26757</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>MYOCARDIAL INFARCTION</i> DUE TO (OR AS A CONSEQUENCE OF): <i>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST: <i>Chronic obstructive pulmonary disease</i>						Approximate Interval Between Onset and Death <i>3h 15</i> <i>26yrs</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic obstructive pulmonary disease</i>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald F. Manger M.D. DME</i>				29c. LICENSE NUMBER <i>009231</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/28/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>DONALD F MANGER Rt 2 Box 828 Cumberland MD 21502</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 01 1995</i>				32. REGISTRAR'S SIGNATURE <i>John H. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14913

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LOLA CHARLENE BREEDEN				2. DATE OF DEATH MONTH DAY YEAR April 25, 1995		3. TIME OF DEATH 6:30 A <sup>M</sup>	
4. SOCIAL SECURITY NUMBER 561-34-7944		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 6, 1928	
9a. FACILITY NAME (If not institution, give street and number) 9114 49th Place				9b. CITY, TOWN OR LOCATION OF DEATH College Park		9c. COUNTY OF DEATH Prince George's	
10a. STATE Maryland				10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION College Park	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 9114 49th Place				10f. ZIP CODE 20740		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Computer Data Entry		16b. KIND OF BUSINESS/INDUSTRY Walter Reed Research			
17. FATHER'S NAME (First, Middle, Last) Jame LeRoy Harris				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ethel Jewell Smith			
19a. INFORMANT'S NAME (Type/Print) Clarence H. Breeden				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9114 49th Place, College Park, Maryland 20740			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 4/26/95		20c. LOCATION — City or Town, State Alexandria, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.B. G...</i>				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>acute cardiorespiratory failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>metastatic carcinoma of bladder</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertensive cardiovascular disease</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>MD</i>				29c. LICENSE NUMBER D00081		29d. DATE SIGNED (Month, Day, Year) 4-26-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. David Anders 8824 Cunningham Drive #B, Berwyn Heights, Maryland 20740							
31. DATE FILED (Month, Day, Year) APR 26 1995		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14914

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LEE GEDDIE BROWN				2. DATE OF DEATH MONTH DAY YEAR April 23, 1995		3. TIME OF DEATH 12:10 A M	
4. SOCIAL SECURITY NUMBER 247-42-4121		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 10, 1922	
8. BIRTHPLACE (State or Foreign Country) South Carolina				9a. FACILITY NAME (If not institution, give street and number) 7606 Villanova Road		9b. CITY, TOWN OR LOCATION OF DEATH Berwyn Heights	
9c. COUNTY OF DEATH Prince George's				10a. STATE Maryland		10b. COUNTY Prince George's	
10c. CITY, TOWN OR LOCATION Berwyn Heights				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 7606 Villanova Road	
10f. ZIP CODE 20740				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II & Korean War				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Legal Clerk		16b. KIND OF BUSINESS/INDUSTRY Department of Justice	
17. FATHER'S NAME (First, Middle, Last) Parker J. Brown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nellie Geddie			
19a. INFORMANT'S NAME (Type/Print) Alma C. Brown				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7606 Villanova Road, Berwyn Heights, Maryland 20740			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 04/26/95		20c. LOCATION — City or Town, State Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.B. Giese</i>				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Coronary Heart failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>diabetic cardiomyopathy</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval between Onset and Death <i>Approx 2 yrs</i> <i>Approx 2 yrs</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Heart failure</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <i>HOSPICE</i>					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Robert D. Deitz</i>				29c. LICENSE NUMBER D01332		29d. DATE SIGNED (Month, Day, Year) 4/24/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Robert D. Deitz 5711 Sarvis Avenue, Riverdale, Maryland 20737-1394							
31. DATE FILED (Month, Day, Year) APR 26 1995				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

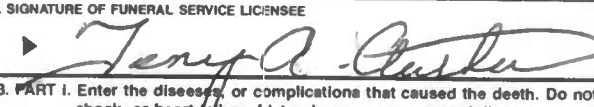


IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14915

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jane Bender				2. DATE OF DEATH MONTH DAY YEAR April 17, 1995				3. TIME OF DEATH 12:10P M					
4. SOCIAL SECURITY NUMBER 181-18-5565				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 15, 1922		8. BIRTHPLACE (State or Foreign Country) Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number) 7746 Bender Road						9b. CITY, TOWN OR LOCATION OF DEATH Landover				9c. COUNTY OF DEATH Prince Georges			
RESIDENCE OF DECEDENT													
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Landover				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 7746 Bender Road				10f. ZIP CODE 20785				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife				16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) John A. Muldoon						18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose O'Connell							
19a. INFORMANT'S NAME (Type/Print) Robert Bender						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1743 Carry Place, Crofton, MD. 21114							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Georgetown Medical Sch, 4/17/95				20c. LOCATION — City or Town, State Washington, D.C.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY Austin Royster Funeral Home 3605 14th. Street N.W. Wash, DC. 20010							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Esthesioneuroblastoma (Advanced Cancer) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.										Approximate Interval Between Onset and Death 2yr			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER 20247		29d. DATE SIGNED (Month, Day, Year) 4/24/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joseph Moe 3800 Reservoir Road NW Washington DC 20007													
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14916

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Rena Elizabeth BRINK</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>23</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>7:20 A M</b>	
4. SOCIAL SECURITY NUMBER <b>171-01-5376</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 11, 1911</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Doctors Community Hospital</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Lanham, MD</b>		8c. COUNTY OF DEATH <b>Prince Georges</b>	
9. RESIDENCE OF DECEDENT				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince Georges</b>	
10c. CITY, TOWN OR LOCATION <b>Seabrook</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>9412 Woodberry Street</b>	
10f. ZIP CODE <b>20706</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Secretary</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Federal Government</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Christian Walker</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Catherine Yeager</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Joseph C. Brink</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5914 89th Avenue, New Carrollton, Maryland 20784</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery 4/27/95</b>		20c. LOCATION — City or Town, State <b>Brentwood, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Marka Yubley</b>				22. NAME AND ADDRESS OF FACILITY <b>Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, MD 20722</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Urinary Tract Infection</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Alzheimer's Disease</b> Approximate Interval Between Onset and Death <b>2</b> <b>2</b> <b>2</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimer's Disease</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>William Rossos</b>				29c. LICENSE NUMBER <b>D16897</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/23/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <b>Dr. William Rossos 5701 85th Avenue New Carrollton, MD 20784</b>							
31. DATE FILED (Month, Day, Year) <b>APR 28 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 687600

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14917

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANITA BROOKS				2. DATE OF DEATH MONTH DAY YEAR APRIL 24, 1995				3. TIME OF DEATH 12.49P M			
4. SOCIAL SECURITY NUMBER 239-86-7498		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 44 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) DEC. 20, 1950		8. BIRTHPLACE (State or Foreign Country) NORTH CAROLINA	
9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGE'S HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY				9c. COUNTY OF DEATH PRINCE GEORGE'S			
10a. STATE MARYLAND				10b. COUNTY PRINCE GEORGE'S				10c. CITY, TOWN OR LOCATION CAPITOL HEIGHTS			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 6852 WALKER MILL ROAD #302				10f. ZIP CODE 20743		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: BLACK			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CASHIER				16b. KIND OF BUSINESS/INDUSTRY PVT.			
17. FATHER'S NAME (First, Middle, Last) ERNEST BROOKS				18. MOTHER'S NAME (First, Middle, Maiden Surname) GRACIE L. STANCIL							
19a. INFORMANT'S NAME (Type/Print) FRANCINE BROOKS/DAUGHTER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6852 WALKER MILL RD #302 CAPITOL HTS., MD 20743							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) FT. LINCOLN CEMETERY 4-28				20c. LOCATION — City or Town, State BRENTWOOD, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Juwana L. Braxton				22. NAME AND ADDRESS OF FACILITY J.B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MD 20785							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CEREBRAL HEMORRHAGE DUE TO (OR AS A CONSEQUENCE OF): LEFT VENTRICULAR HYPERTROPHY DUE TO (OR AS A CONSEQUENCE OF): HYPERTENSION DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 19 hours											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER M. JUTCOVICH, MD		29c. LICENSE NUMBER D31089		29d. DATE SIGNED (Month, Day, Year) April 25, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type Print) M. JUTCOVICH, MD		31. DATE FILED (Month, Day, Year) APR 28 1995								32. REGISTRAR'S SIGNATURE Julia Davidson Randall	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14918

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WILSON D. BUTLER</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>27</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>3:45 A M</b>	
4. SOCIAL SECURITY NUMBER <b>578-54-0410</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>52</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT. 4, 1942</b>	
8. BIRTHPLACE (State or Foreign Country) <b>GREENWOOD, SC</b>				9a. FACILITY NAME (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRING</b>	
9c. COUNTY OF DEATH <b>MONTGOMERY</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>PRINCE GEORGE'S</b>	
10c. CITY, TOWN OR LOCATION <b>CAPITOL HEIGHTS</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>7105 GIDDING DRIVE</b>	
10f. ZIP CODE <b>20743</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3YRS.</b> College (1-4 or 5+) <b>CAPITAL BUYER</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>KAISER PERMANENTE (PVT.)</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>HAROLD O. BUTLER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>NELL SANDERS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>FANNIE L. BUTLER/ WIFE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7105 GIDDING DRIVE CAPITOL HTS., MD 20743</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>FT. LINCOLN CEMETERY 5-1</b>		20c. LOCATION — City or Town, State <b>BRENTWOOD, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Shawana L. Braxton</i>				22. NAME AND ADDRESS OF FACILITY <b>J.B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MD 20785</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardio pulmonary Arrest</i> DUE TO (OR AS A CONSEQUENCE OF): <i>End stage Renal Failure</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Hypoxic encephalopathy</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Multifactorial: DM, HTN, CAD</i>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>4/27/95</b>		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>	
29c. LICENSE NUMBER <b>D 42033</b>				29d. DATE SIGNED (Month, Day, Year) <b>4/27/95</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>10810 Connecticut Ave Kensington MD 20895</b>							
31. DATE FILED (Month, Day, Year) <b>APR 28 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14919

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>James D Bush</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 19, 1995</b>				3. TIME OF DEATH <b>220P</b>			
4. SOCIAL SECURITY NUMBER <b>215-56-7604</b>				5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>46</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 31, 1948</b>		8. BIRTHPLACE (State or Foreign Country) <b>Newburg, MD</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>6708 Hillcroft Place</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Ft. Washington</b>			9c. COUNTY OF DEATH <b>Prince George's</b>		
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Prince George's</b>				10c. CITY, TOWN OR LOCATION <b>Oxon Hill</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1811 Ironton Drive</b>				10f. ZIP CODE <b>20745</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Truck Driver - Metro</b>			
16b. KIND OF BUSINESS/INDUSTRY <b>Private</b>				17. FATHER'S NAME (First, Middle, Last) <b>Moses E. Bush, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Maude Greene</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Joanne Bush</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1811 Ironton Drive, Oxon Hill, MD 20745</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Harmony Memorial Park 4/25/95</b>				20c. LOCATION — City or Town, State <b>Landover, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>John T. Stewart III</b>				22. NAME AND ADDRESS OF FACILITY <b>STEWART FUNERAL HOME 4001 Benning Road, N.E., Washington, D. C.</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arteriosclerotic cerebro-vascular disease</b> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>years</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Augusto P. Rodriguez MD</b>				29c. LICENSE NUMBER <b>021230</b>				29d. DATE SIGNED (Month, Day, Year) <b>April 20, 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <b>Augusto P. Rodriguez MD 5009 Rayburn Ct. Cap. Spr. Md 20748</b>											
31. DATE FILED (Month, Day, Year) <b>APR 26 1995</b>				32. REGISTRAR'S SIGNATURE <b>John A. Marshall</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

6

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM HOWARD BECKER</b>				2. DATE OF DEATH MONTH <b>APR</b> DAY <b>6</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>7:24</b> P M	
4. SOCIAL SECURITY NUMBER <b>213-38-2454</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 28, 1916</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Md.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>NATIONAL NAVAL MEDICAL CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BETHESDA</b>	
9c. COUNTY OF DEATH <b>MONTGOMERY</b>				10a. STATE <b>Md.</b>		10b. COUNTY <b>Queen Anne's</b>	
10c. CITY, TOWN OR LOCATION <b>Stevensville</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>125 Bay Drive</b>	
10f. ZIP CODE <b>21666</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 grade</b> College (1-4 or 5+) <b>Military U.S. Navy</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>U.S. Navy</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Navy</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William Francis Becker</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Amelia Carter Becker</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Noreen D. Becker</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>125 Bay Drive Stevensville, Md. 21666</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. LOCATION — City or Town, State <b>4/8/95 Balto. Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas K. Hefenbein</i>				22. NAME AND ADDRESS OF FACILITY <b>Tom Helfenbein Funeral Home 106 Shamrock Rd. Chester, Md.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>METASTATIC ESOPHAGEAL ADENOCARCINOMA</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>8 months</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John H. Kellogg MD</i>				29c. LICENSE NUMBER <b>MD-047454-L (PA)</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 7, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOHN H. KELLOGG, LCDR, MC, USNR</b> <b>NATIONAL NAVAL MEDICAL CENTER</b> <b>BETHESDA MD 20889-5600</b>							
31. DATE FILED (Month, Day, Year) <b>APR 10 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julia Benson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 14921

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Frederick William Bloom				2. DATE OF DEATH MONTH DAY YEAR April 5, 1995		3. TIME OF DEATH 16:45 M	
4. SOCIAL SECURITY NUMBER 216-09-0987		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 23, 1908	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) Meredian Nursing Center of Corsica Hills		9b. CITY, TOWN OR LOCATION OF DEATH Centreville	
9c. COUNTY OF DEATH Queen Anne's				10a. STATE Maryland		10b. COUNTY Baltimore Co.	
10c. CITY, TOWN OR LOCATION Towson				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 1000 East Joppa Road Apt. #302	
10f. ZIP CODE 21204				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor and Vice President		16b. KIND OF BUSINESS/INDUSTRY Poplar Club Beverage Company	
17. FATHER'S NAME (First, Middle, Last) Percy Bloom				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jane Carr			
19a. INFORMANT'S NAME (Type/Print) Frances L. Taylor				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1715 Bayside Drive, Chester, Md. 21619			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Md. Veteran's Cemetery April 10, 1995		20c. LOCATION — City or Town, State Hurlock, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas K. Helfenbein				22. NAME AND ADDRESS OF FACILITY Tom Helfenbein Funeral Homes, P.A. 106 Shamrock Rd., Chester, Md. 21619			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. RESPIRATORY FAILURE							
DUE TO (OR AS A CONSEQUENCE OF):							
b. CORD							
DUE TO (OR AS A CONSEQUENCE OF):							
c. PHARYNGEAL CARCINOMA							
DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Eric F. Ciganek M.D.				29c. LICENSE NUMBER D35043		29d. DATE SIGNED (Month, Day, Year) 4/6/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Eric F. Ciganek, Md. 109 S. Commerce St., Centreville, Md. 21617							
31. DATE FILED (Month, Day, Year) APR 06 1995				32. REGISTRAR'S SIGNATURE Julius Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE VICTIM ROOM

THE VICTIM ROOM

THE VICTIM ROOM

THE VICTIM ROOM





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DONALD LEE BURNS				2. DATE OF DEATH MONTH DAY YEAR APRIL 23, 1995		3. TIME OF DEATH 1616 P M					
4. SOCIAL SECURITY NUMBER 212-66-1912		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 40 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 29, 1955		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) 707 KIMBERLY WAY				9b. CITY, TOWN OR LOCATION OF DEATH STEVENSVILLE				9c. COUNTY OF DEATH QUEEN ANNES			
10a. STATE Maryland		10b. COUNTY Queen Anne's		10c. CITY, TOWN OR LOCATION Stevensville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 707 Kimberly Way				10f. ZIP CODE 21666		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machinist		16. KIND OF BUSINESS/INDUSTRY N.R.L. & Assoc., Inc.							
17. FATHER'S NAME (First, Middle, Last) William Irvin Burns				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elmyra Sparks							
19a. INFORMANT'S NAME (Type/Print) Mary Lou Black				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 Kimberly Way, Stevensville, Md. 21666							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Stevensville Cemetery		DATE Apr. 26, 1995		20c. LOCATION — City or Town, State Stevensville, Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas K. Helfenbein				22. NAME AND ADDRESS OF FACILITY Tom Helfenbein Funeral Homes, P.A. 106 Shamrock Rd., Chester, Md. 21619							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Arterio-sclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Theodore M. King					29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) APRIL 24, 1995				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) APR 25 1995				32. REGISTRAR'S SIGNATURE John Denson-Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

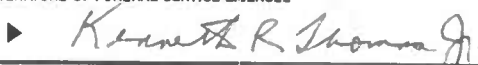
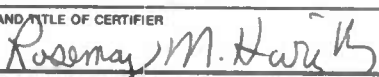
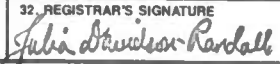
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14923

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>SALLIE STEWART BETTS</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>27</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>10:00 am</b> M	
4. SOCIAL SECURITY NUMBER <b>219-07-8906</b>		5. SEX <b>1</b> <input type="checkbox"/> M <b>2</b> <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>90</b> YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 18 1904</b>				8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Mallard Bay Nursing Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cambridge</b>		9c. COUNTY OF DEATH <b>Dorchester</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Dorchester</b>		10c. CITY, TOWN OR LOCATION <b>Cambridge</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>520 Glenburn Ave.</b>				10f. ZIP CODE <b>21613</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>10</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>sewing machine operator</b>		16b. KIND OF BUSINESS/INDUSTRY <b>garment manufacturing</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William H. P. Stewart</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Laura Spear</b>			
19a. INFORMANT'S NAME (Type/Print) <b>James E. Wilson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4219 Webster Rd., Havre de Grace MD 21078</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dorchester Memorial Park 5/1</b>		20c. LOCATION — City or Town, State <b>Cambridge Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Thomas Funeral Home 700 Locust St. Cambridge MD 21613</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lung Cancer</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>6 months</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>							24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Rosemary M. Harris, M.D.</b>				29c. LICENSE NUMBER <b>D-43707</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 27, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Rosemary M. Harris, M.D. 408 Byrn St., Cambridge MD 21613</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 03 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Robert Michael Brown 69  
888-27-1224  
533 7944



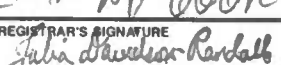
95 14924

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
1 - STATE REGISTRAR											
CERTIFICATE OF DEATH											
REG. NO.											
1. DECEDENT'S NAME (First, Middle, Last) <b>ROBERT MICHAEL BROWN</b>				2. DATE OF DEATH MONTH <b>5</b> DAY <b>3</b> YEAR <b>95</b>		3. TIME OF DEATH <b>0400</b> M					
4. SOCIAL SECURITY NUMBER <b>034-16-1893</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>69</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>11-21-25</b>		8. BIRTHPLACE (State or Foreign Country) <b>Massachusetts</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Anne Arundel Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>					
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Arnold</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>652 Magothy View Drive</b>				10f. ZIP CODE <b>21012</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1956-1977</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>7</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Systems Analyst</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Defense Contractor</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Thomas Brown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret Campbell</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Claire Brown</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as # 10</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arlington Natl. Cem. 5-5-95 Arlington, VA</b>		20c. LOCATION — City or Town, State							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Barranco and Sons Funeral Home 495 Ritchie Hwy Severna Park, MD 21144</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>R PARIETAL HEMORRHAGE =</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): <b>intra ventricular extension</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death <b>20h</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>NONE KNOWN</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  <b>MICHAEL J. LARENA MD</b>		29c. LICENSE NUMBER <b>021438</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/31/95</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MICHAEL J. LARENA MD WORKING CLY AT NEW ANNAPOLIS MEDICAL</b>											
31. DATE FILED (Month, Day, Year) <b>MAY 09 1995</b>		32. REGISTRAR'S SIGNATURE 									



95 14925

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Gordon Truman Boyd, Jr.				2. DATE OF DEATH MONTH DAY YEAR May 5 1995		3. TIME OF DEATH 9:32A M	
4. SOCIAL SECURITY NUMBER 217-09-1363		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) February 21, 1917	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not Institution, give street and number) Anne Arundel Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Annapolis		9c. COUNTY OF DEATH Anne Arundel	
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Annapolis		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3522 Narragansett Avenue				10f. ZIP CODE 21403		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Manager		16b. KIND OF BUSINESS/INDUSTRY Census Bureau/Federal Gov't			
17. FATHER'S NAME (First, Middle, Last) Gordon Jackson Boyd				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sevilla Truman			
19a. INFORMANT'S NAME (Type/Print) Corrine S. Boyd				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3522 Narragansett Ave., Annapolis, Md. 21403			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Crematory		DATE 6-9		20c. LOCATION — City or Town, State Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wayne P. Deaky</i>				22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>chronic renal failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>arterio sclerosis</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>organic dementia</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gregory A. Mitchell MD</i>				29c. LICENSE NUMBER D14758		29d. DATE SIGNED (Month, Day, Year) May 5 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gregory A. Mitchell, M.D. 205 Ridgley Avenue Annapolis, MD 21401 (410-268-3232)							
31. DATE FILED (Month, Day, Year) MAY 08 1995		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14926

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Clarence T. Butler Sr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 30 95</b>		3. TIME OF DEATH <b>&amp; 7:00 P M</b>	
4. SOCIAL SECURITY NUMBER <b>216-14-5779</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JAN 15, 1920</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>10904 Crossroad Trail</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Brandywine</b>		9c. COUNTY OF DEATH <b>Prince George</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Prince George</b>		10c. CITY, TOWN OR LOCATION <b>Brandywine</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>10904 Crossroad Trail</b>			
10f. ZIP CODE <b>20613</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1942 - 1945</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Mechanic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Buffalo Sand + Gravel</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Unknown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Butler</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Helen Butler</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10904 Crossroad Trail Brandywine MD 20613</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Resurrection 5/5/95</b>		20c. LOCATION — City or Town, State <b>Clinton MD</b>		20d. DATE <b>5/5/95</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Lloyd Estey</b>				22. NAME AND ADDRESS OF FACILITY <b>Adams Funeral Home, Aquasco MD 20608</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>MYO CARDIAL INFARCTION</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>CORONARY ARTERY DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					
Approximate Interval Between Onset and Death <b>1HR</b>		Approximate Interval Between Onset and Death <b>5HRS</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CANCER OF BLADDER</b> <b>CANCER OF PROSTATE</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Joseph P CARUSO MD</b>		29c. LICENSE NUMBER <b>0-18013</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/1/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Joseph P CARUSO MD 7700 OLD BRANCH AVE CLINTON, MD 20735</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 05 1995</b>		REGISTRAR'S SIGNATURE <b>John Andrew Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14927

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LORETTA MAE CARNEY				2. DATE OF DEATH MONTH DAY YEAR May 1, 1995				3. TIME OF DEATH 11:45 a M									
4. SOCIAL SECURITY NUMBER 217-10-4353				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Jul 30, 1915		8. BIRTHPLACE (State or Foreign Country) MD					
9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL								9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND				9c. COUNTY OF DEATH ALLEGANY					
10a. STATE MD				10b. COUNTY Allegany				10c. CITY, TOWN OR LOCATION Cumberland				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 506 Prince George Street								10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Spinning Dept.				16b. KIND OF BUSINESS/INDUSTRY Textile									
17. FATHER'S NAME (First, Middle, Last) John Joseph Carney, Sr.								18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Helena (Keenam)									
19a. INFORMANT'S NAME (Type/Print) Mary Louise McGregors								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Club House Road; LaVale, MD 21502									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Mary's Cemetery 05/04				20c. LOCATION — City or Town, State Cumberland, MD									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i>								22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): One Hour b. Aspiration DUE TO (OR AS A CONSEQUENCE OF): One Hour c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Coronary Artery Disease												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>																	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
				28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Sunil Gupta</i>		29c. LICENSE NUMBER D 33280		29d. DATE SIGNED (Month, Day, Year) May 1, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Sunil Gupta-Johnson Height's Medical Building-Cumberland, MD 21502																	
31. DATE FILED (Month, Day, Year) MAY 03 1995												32. REGISTRAR'S SIGNATURE <i>Julia ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14928

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BERTHA COHEN</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>22</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>0:30 P</b>	
4. SOCIAL SECURITY NUMBER <b>26 578-26-169</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9-21-1923</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Southern Maryland Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Clinton</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGES</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>PG</b>		10c. CITY, TOWN OR LOCATION <b>Clinton</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>9211 Stuart Lane</b>				10f. ZIP CODE <b>20735</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Unknown</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Unknown</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Unknown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Person Rep.</b> <b>Desire Foster-Jackson Ads</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9211 Stuart Lane Clinton, Md. 20735</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Harmony Cemetery</b>		20c. LOCATION — City or Town, State <b>Landover, Md.</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stanley B. Barry</i>				22. NAME AND ADDRESS OF FACILITY <b>Plunkett Funeral Home</b> <b>2504 28th Street, N. E.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. Ruptured diverticulum Atherosclerosis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death <b>days</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Acid, Diabetes mellitus</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Frank M. Ryan</i>				29c. LICENSE NUMBER <b>DM431</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/28/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Frank M. Ryan M.D. 6188 Oxon Hill Rd #60 Oxon Hill, MD 20745</b>							
31. DATE FILED (Month, Day, Year) <b>APR 26 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.




IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14929

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY LEE CHASE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 22, 1995</b>		3. TIME OF DEATH <b>3:15p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>579-44-4447</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH MONTH DAY YEAR <b>3/8/08</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>DOCTORS COMMUNITY HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>LANHAM-SEABROOK</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGE'S CO.</b>	
10a. STATE <b>DC</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Washington</b>	
10e. STREET AND NUMBER <b>2000 Connecticut Avenue N.W.</b>				10f. ZIP CODE <b>20008</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Unknown</b> College (1-4 or 8+) <b>Unknown</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Domestic</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Joseph Chase</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Cora Bailey</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Lena B. Jenkins</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>690 Nicholson St NW, DC 20011</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lincoln Memorial</b>		DATE <b>4/27/95</b>		20c. LOCATION — City or Town, State <b>Suitland, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>John T. Rhines Co., Inc. 3030 12th St NE, DC 20017</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebrovascular Disease</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CONGESTIVE HEART FAILURE</b> <b>HYPERTENSION</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>039550</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/23/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>George C. Hajjar, Jr. M.D. 4850 Forbes Blvd. Lanham, Md. 20706</b>							
31. DATE FILED (Month, Day, Year) <b>APR 28 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JONATHAN EARL COLEMAN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 21 1995</b>		3. TIME OF DEATH <b>6:15P</b>	
4. SOCIAL SECURITY NUMBER <b>129 48 6432</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>36</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jun 16 1958</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>12204 WINDER PLACE.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>FORT WASHINGTON</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGES.</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Fort Washington</b>		10d. INSIDE CITY - LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>12204 Winder Place</b>				10f. ZIP CODE <b>20744</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>4+</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Commercial Baker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>US Govt</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George Coleman</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Georgette Addison</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Phyllis W. Coleman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Ch. Cemetery</b>		DATE <b>25 Apr</b>		20c. LOCATION — City or Town, State <b>Alexandria, VA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Nelson E. Greene Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>GREENE FUNERAL HOME 814 Franklin Street Alexandria, VA 22314</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ASTROCYTOMA</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HUMAN IMMUNODEFICIENCY VIRUS SEROPOSITIVITY</b>							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Theodore M. King</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 22 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201.</b>							
31. DATE FILER (Month, Day, Year) <b>APR 27 1995</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson-Hardell</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14931

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Catherine CLARK</u>				2. DATE OF DEATH MONTH <u>April</u> DAY <u>24</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>3:45 A.</u> M	
4. SOCIAL SECURITY NUMBER <u>225-14-2796</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <u>73</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Oct. 28, 1921</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Doctors Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Lanham</u>		9c. COUNTY OF DEATH <u>Prince Georges</u>	
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Prince Georges</u>		10c. CITY, TOWN OR LOCATION <u>Bladensburg</u>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>4229 58th. Ave.</u>				10f. ZIP CODE <u>20710</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>X</u>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8</u> College (1-4 or 5+) <u></u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Housekeeper</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Private Industry</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Allen Easley</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Ethel Tucker</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Rosemary Gallman</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4209 58th. Ave., Bladensburg, Md., 20710</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Piney Grove Church Cemetery</u>		20c. LOCATION — City or Town, State <u>4/28/95</u> <u>Halifax, Va.</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>W. G. Jeffers</u>				22. NAME AND ADDRESS OF FACILITY <u>Frazier Funeral Home</u> <u>389 Rhode Island Av., NW, Washington, D.C.</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Cardiorespiratory arrest</u> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <u>Due to (or as a consequence of):</u> b. <u>Congestive heart failure with</u> c. <u>Secondary stroke</u> d. <u></u>							Approximate Interval Between Onset and Death <u>1 year</u>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u>				29c. LICENSE NUMBER <u>D14252</u>		29d. DATE SIGNED (Month, Day, Year) <u>4/24/95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>7313 Harrower Pkwy. A, Greenbelt, Md. 20770</u>							
31. DATE FILED (Month, Day, Year) <u>APR 26 1995</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10



95-2383-033  
B.K.S

95 14932

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOSEPH C. COLES</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>23</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>4:15 P.M.</b>							
4. SOCIAL SECURITY NUMBER <b>231-06-7008</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>33</b> YRS.		IF UNDER 1 YEAR MONTHS <b>02</b> DAYS <b>20</b>		IF UNDER 24 HRS. HOURS <b>02</b> MIN. <b>62</b>		7. DATE OF BIRTH (Month, Day, Year) <b>02-20-62</b>		8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>5620 WHITFIELD CHAPEL ROAD</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>LANHAM</b>				9c. COUNTY OF DEATH <b>PRINCE GEORGES</b>					
RESIDENCE OF DECEDENT															
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Prince George's</b>				10c. CITY, TOWN OR LOCATION <b>Lanham</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>5620 Whitfield Chapel Road</b>						10f. ZIP CODE <b>20706</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College</b>						16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Nurse</b>				16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) <b>James Coles</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Constance (Unknown)</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Joseph Liggon</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Dixie Airport Rd., Madison Heights, Va.</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>Scott Zion Church Ceme.</b>				DATE <b>4/27/95</b>		20c. LOCATION — City or Town, State <b>Amherst Co., Va.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John T. Stewart, III</i>						22. NAME AND ADDRESS OF FACILITY <b>STEWART FUNERAL HOME</b> <b>4001 Benning Rd. N.E., Wash. D.C.</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Fatty Liver</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.												Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Arteriosclerotic Cardiovascular Disease</b>												24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theresa M. King</i>				29c. LICENSE NUMBER <b>O.C.M.E</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 24, 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Theresa M. King</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>															
31. DATE FILED (Month, Day, Year) <b>APR 26 1995</b>				32. REGISTRAR'S SIGNATURE <i>John D. Walker</i>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14933

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Erma Mae Cooke				2. DATE OF DEATH MONTH DAY YEAR April 4 1995				3. TIME OF DEATH 12:02 p.m.			
4. SOCIAL SECURITY NUMBER 238-42-3806		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 5, 1927		8. BIRTHPLACE (State or Foreign Country) Garner, N.S.			
9a. FACILITY NAME (If not institution, give street and number) Holy Cross				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring				9c. COUNTY OF DEATH Montgomery			
10a. STATE Md.				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 10820 Georgia Av.				10f. ZIP CODE 20902				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (14 or 5+) 10				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY private industry			
17. FATHER'S NAME (First, Middle, Last) Theodore R. Cooke				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lilly Belle Jordan							
19a. INFORMANT'S NAME (Type/Print) Monica Cooke				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10820 Georgia Av., Silver Spring, Md., 20902							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Park 4/8/95				20c. LOCATION — City or Town, State Landover, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W. J. Jeffers</i>				22. NAME AND ADDRESS OF FACILITY Frazier Funeral Home, Inc. 389 Rhode Island Av., NW, Washington, D.C.							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Gastrointestinal Bleed</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Renal failure</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Dilated Cardiomyopathy</i> DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 2 hrs. years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER B41931		29d. DATE SIGNED (Month, Day, Year) April 4, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R Shumacher, MD 2309 Shorefield Rd Wheaton, MD 20902											
31. DATE FILED (Month, Day, Year) APR 26 1995				32. REGISTRAR'S SIGNATURE <i>John A. Anderson-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14934

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Nettie Irene Creighton				2. DATE OF DEATH MONTH DAY YEAR April 29 1995		3. TIME OF DEATH 1:20 a m	
4. SOCIAL SECURITY NUMBER 213-24-0567		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec 7, 1905	
9a. FACILITY NAME (If not institution, give street and number) Dorchester General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cambridge		9c. COUNTY OF DEATH Dorchester	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Dorchester		10c. CITY, TOWN OR LOCATION Cambridge		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 420 Willis Street				10f. ZIP CODE 21613		10g. CITIZEN OF WHAT COUNTRY? US	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary Secondary (0-12) 11 College (1-4 or 5+) 1		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner/Manager		16b. KIND OF BUSINESS/INDUSTRY Restaurant			
17. FATHER'S NAME (First, Middle, Last) Acia Parks				16. MOTHER'S NAME (First, Middle, Maiden Surname) Geneva White			
19a. INFORMANT'S NAME (Type/Print) Annabelle C. Meredith				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 420 Willis St. Cambridge, Maryland 21613			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dorchester Memorial Park 5/2		20c. LOCATION — City or Town, State Cambridge, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St. Cambridge, Md. 21613			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerotic Vascular Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 72 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Left hip fracture, Organic Brain Syndrome, Advanced Age DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 022-773		29d. DATE SIGNED (Month, Day, Year) 5/3/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Hubert L. Fiery, M.D. 503 Byrn Street Cambridge, MD 21613							
31. DATE FILED (Month, Day, Year) MAY 03 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14935

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Richard Henry Crompton, Jr.				2. DATE OF DEATH MONTH DAY YEAR May 4, 1995		3. TIME OF DEATH 5A M	
4. SOCIAL SECURITY NUMBER 212-03-9283		5. SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-3-1921	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 366 South Drive		9b. CITY, TOWN OR LOCATION OF DEATH Severna Park	
9c. COUNTY OF DEATH Anne Arundel				10a. STATE Maryland		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Severna Park				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 366 South Drive	
10f. ZIP CODE 21146				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12+ College (1-4 or 5+) 12+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Plumber		16b. KIND OF BUSINESS/INDUSTRY Construction	
17. FATHER'S NAME (First, Middle, Last) Richard H. Crompton				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose			
19a. INFORMANT'S NAME (Type/Print) Mrs. Betty Greene				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 65 Glade Road E. Hampton, N.Y. 11937			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Cemetery 5-8-95 Crownsville, MD		20c. LOCATION — City or Town, State MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James E. Barranco</i>				22. NAME AND ADDRESS OF FACILITY Barranco & Sons Funeral Home 21146 495 Ritchie Hwy Severna Park, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Melastole carcinoma of colon</i> Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Carcinoma of colon</i> c. d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 3 months 4 months							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Ischemic heart disease</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. End. Chen</i>				29c. LICENSE NUMBER D01865		29d. DATE SIGNED (Month, Day, Year) 5/4/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Glen and Ethel 8 Evergreen Road Severna Park							
31. DATE FILED (Month, Day, Year) MAY 09 1995		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i> MAY 21 1995					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14936

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>THELMA L. COLLISON</b> Thelma Lillian Collison				2. DATE OF DEATH MONTH <b>05</b> DAY <b>05</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>11:15 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>213-28-5203</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>92</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>09/15/02</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Meridian Spa Creek</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>		8c. COUNTY OF DEATH <b>A.A.</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Annapolis</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>24 Jefferson Place</b>				10f. ZIP CODE <b>21401</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Civil Service</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Civil Service</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Government Work</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Harry Luden Norris</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Susan Alice Gutschall</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Shirley Fuller</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>24 Jefferson Place, Annapolis, Md. 21401</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Fort Lincoln Crematory</b>		DATE <b>6-9</b>		20c. LOCATION — City or Town, State <b>Brentwood, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John M. Taylor</i>				22. NAME AND ADDRESS OF FACILITY <b>John M. Taylor Funeral Home Inc., 147 Duke of Gloucester St., Annapolis, Md. 21401</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MULTIPLE ORGAN FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Recent left sided STROKE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Arteriosclerotic Cardiovascular disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Recent left ventricular failure; SP ABG; Cardiac Pacemaker; Dermatitis.</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Peter Verkouwen</i>				29c. LICENSE NUMBER <b>010653</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/6/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PETER VERKOWEN MD. Forest Dr. Annapolis MD. 21403</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 08 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14937

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ETHEL L. DRUMMOND				2. DATE OF DEATH MONTH DAY YEAR April 23, 1995		3. TIME OF DEATH 3:00 A M	
4. SOCIAL SECURITY NUMBER 216-82-1016		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 56 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 22, 1939	
9a. FACILITY NAME (If not institution, give street and number) 5809 40th Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Hyattsville		9c. COUNTY OF DEATH Prince George's	
10a. STATE Maryland				10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Hyattsville	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 5809 40th Avenue				10f. ZIP CODE 20782		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nurses Assistant		16b. KIND OF BUSINESS/INDUSTRY Private			
17. FATHER'S NAME (First, Middle, Last) Joseph Bailey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emeline Grant			
19a. INFORMANT'S NAME (Type/Print) Virginette Smith				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7200 Goodluck Road, Lanham, Maryland 20706			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MD National Memorial Park 4/29/95		20c. LOCATION — City or Town, State Laurel, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.B. Gessen</i>				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Colorectal Carcinoma DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 2 Years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. none						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>William K. Kelly</i>		29c. LICENSE NUMBER D39979		29d. DATE SIGNED (Month, Day, Year) April 25, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. William K. Kelly, M.D. Washington Cancer Institute							
31. DATE FILED (Month, Day, Year) APR 26 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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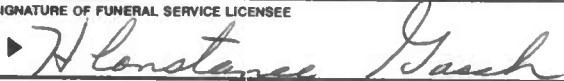






95 14938

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARTHA JANE SHULTZ DIETRICH</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 18, 1995</b>				3. TIME OF DEATH <b>6:15 p</b>					
4. SOCIAL SECURITY NUMBER <b>303-07-8706</b>				5. SEX <b>1</b> <input type="checkbox"/> M <b>2</b> <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 19, 1916</b>		8. BIRTHPLACE (State or Foreign Country) <b>Indiana</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>4616 Guilford Road</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>College Park</b>				9c. COUNTY OF DEATH <b>Prince George's</b>			
RESIDENCE OF DECEDENT													
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Prince George's</b>				10c. CITY, TOWN OR LOCATION <b>College Park</b>				10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4616 Guilford Road</b>						10f. ZIP CODE <b>20740</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Personnel Placement Officer</b>				15b. KIND OF BUSINESS/INDUSTRY <b>United States Government</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Charles Russell Shultz</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Florence D. McIntyre Shultz</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Dr. Charles D. Dietrich</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11105 Buckwood Lane, Rockville, Maryland 20852</b>							
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Highland Lawn Cemetery 4/22/95</b>				20c. LOCATION — City or Town, State <b>Terre Haute, Indiana</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY <b>Francis GASCH's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Amyotrophic Lateral Sclerosis</b> DUE TO (OR AS A CONSEQUENCE OF):										Approximate Interval Between Onset and Death <b>4 Years</b>			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
b. DUE TO (OR AS A CONSEQUENCE OF):													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Ischemic Heart Disease. Osteoarthritis</b>													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER <b>D04686</b>				29d. DATE SIGNED (Month, Day, Year) <b>April 20, 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Robert F. Dyer, M.D. 5530 Wisconsin Avenue, Chevy Chase, Maryland 20815</b>													
31. DATE FILED (Month, Day, Year) <b>APR 24 1995</b>						32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

20

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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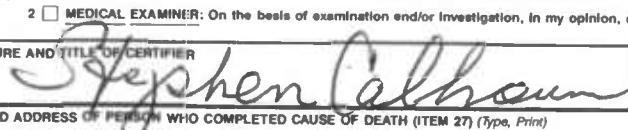
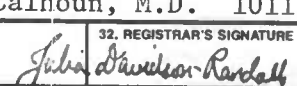
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text at the bottom of the page, possibly a signature or date.

95 14939

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PIERCE CLARENCE DAVIS				2. DATE OF DEATH MONTH DAY YEAR April 23, 1995		3. TIME OF DEATH 9:55 P. M.	
4. SOCIAL SECURITY NUMBER 578-58-2637		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 49 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 6, 1946	
8a. FACILITY NAME (If not institution, give street and number) HOLY CROSS HOSPITAL				8b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING		8c. COUNTY OF DEATH MONTGOMERY	
9. RESIDENCE OF DECEDENT				10a. STATE MARYLAND		10b. COUNTY PRINCE GEORGES	
10c. CITY, TOWN OR LOCATION TEMPLE HILLS				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 3921 23rd Parkway				10f. ZIP CODE 20748		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FINANCE ANALYST		16b. KIND OF BUSINESS/INDUSTRY SELF-EMPLOYED			
17. FATHER'S NAME (First, Middle, Last) WILLIE P. DAVIS				18. MOTHER'S NAME (First, Middle, Maiden Surname) PEARL BROWER			
19a. INFORMANT'S NAME (Type/Print) RHONDA Y. DAVIS (WIFE)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2240 Dawn Lane, Temple Hills, Md. 20748			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HARMONY MEMORIAL PARK		DATE 4/29		20c. LOCATION — City or Town, State LANDOVER, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M859		22. NAME AND ADDRESS OF FACILITY ALEXANDER S. POPE FUNERAL HOMES 5538 Marlboro Pike, Forestville, Md 20747					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ii. SHOCK DUE TO (OR AS A CONSEQUENCE OF): b. MASSIVE OCCIPITAL HEMORRHAGE DUE TO (OR AS A CONSEQUENCE OF): c. HERNIATION AND COMPRESSION CEREBELLUM AND MEDULLA DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) NA		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED NA				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D28181		29d. DATE SIGNED (Month, Day, Year) April 26, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Stephen Calhoun, M.D. 1011 North Capitol St., N.E., Washington, D.C. 20001							
31. DATE FILED (Month, Day, Year) APR 28 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

10 0/10

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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95 14940

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Vivian E Davis</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 22, 1995</i>		3. TIME OF DEATH <i>259A</i>	
4. SOCIAL SECURITY NUMBER <i>577-38-8554</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>65</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>September 10, 1929</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>SOUTHERN MARYLAND HOSPITAL</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>CLINTON</i>		9c. COUNTY OF DEATH <i>PRINCE GEORGE'S</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Prince George's</i>		10c. CITY, TOWN OR LOCATION <i>Bladensburg</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>5802 Annapolis Road #115</i>				10f. ZIP CODE <i>20710</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>2</i> College (1-4 or 5+) <i>2</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Mailroom Supervisor</i>		15b. KIND OF BUSINESS/INDUSTRY <i>Department of Defense</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Alphonso Lee</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Alline Savoy</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Vivian L. Davis (Daughter)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5802 Annapolis Road #115 Bladensburg, Maryland 20710</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Mount Olivet Cemetery</i>		DATE <i>4/28/95</i>		20c. LOCATION — City or Town, State <i>Washington, D.C.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute hypertension, coronary plaque, cardiovascular</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Atherosclerosis</i>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i>				29c. LICENSE NUMBER <i>D212 30</i>		29d. DATE SIGNED (Month, Day, Year) <i>April 23, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augusto P. Rodriguez MD, 5009 Rayburn Ct. Cap. Spr. MD 20748</i>							
31. DATE FILED (Month, Day, Year) <i>APR 27 1995</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LEONA J. DOYLE				2. DATE OF DEATH MONTH DAY YEAR APRIL 20 95		3. TIME OF DEATH 5:00 A M					
4. SOCIAL SECURITY NUMBER 130 07 1636		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 26, 1914		8. BIRTHPLACE (State or Foreign Country) Airlie, N.C.			
9a. FACILITY NAME (If not institution, give street and number) Prince George Hospital Center				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly			9c. COUNTY OF DEATH P.G.				
10a. STATE Maryland				10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION <del>Hyattsville</del> Forestville		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 7420 Marlboro Pike				10f. ZIP CODE 20747		10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES no		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: no		14. RACE — American Indian, Black, White, etc. Specify: Black					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress		16b. KIND OF BUSINESS/INDUSTRY Self-employed							
17. FATHER'S NAME (First, Middle, Last) Robert Jackson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Lee							
19a. INFORMANT'S NAME (Type/Print) Robert F. Jackson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 80 Betsy Brown Circle Port Chester, N.Y.							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lincoln Memorial Cemetery 4/27/95		20c. LOCATION — City or Town, State Suitland, Md.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John T. Stewart III</i>				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 4001 Benning Road, N.E.							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 2 days			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular disease								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>George C. Hajjar, Jr.</i> M.D.				29c. LICENSE NUMBER 039550		29d. DATE SIGNED (Month, Day, Year) 4/20/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George C. Hajjar, Jr. M.D. 4850 Forbes Blvd. Lanham, Md. 20706											
31. DATE FILED (Month, Day, Year) APR 27 1995				32. REGISTRAR'S SIGNATURE <i>John A. Anderson</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Lyla V Davis</u>				2. DATE OF DEATH MONTH <u>April</u> DAY <u>22</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>5:20 A.M.</u>	
4. SOCIAL SECURITY NUMBER <u>237-82-7452</u>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>45</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>July 22, 1949</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Howard County General Hosp.</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Columbia, Md.</u>		9c. COUNTY OF DEATH <u>Howard County</u>	
10a. STATE <u>Maryland</u>				10b. COUNTY <u>Howard County</u>		10c. CITY, TOWN OR LOCATION <u>Columbia, Md.</u>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <u>6334 Cedar Lane</u>			
10f. ZIP CODE <u>21044</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) <input type="checkbox"/> College (14 or 15+) <input checked="" type="checkbox"/> <u>5+</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>School Teacher</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Prince Georges Co. Public Schools</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Jobe Davis</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Ida Mae Alston</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Ada M. Davis Sister</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>6207 Harley Lane Camp Springs, Md. 20748</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Davis Family Cemetery 4/26 Warrenton, N.C.</u>		20c. LOCATION — City or Town, State		20d. DATE <u>4/26</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>F. Bernard Hunt</u>				22. NAME AND ADDRESS OF FACILITY <u>Hunt Funeral Home 1420 34th St. S.E. Wash. D.C. 20020</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Aspiration Pneumonia</u>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. <u>Multiple Sclerosis</u>							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Steven Geller M.D.</u>				29c. LICENSE NUMBER <u>d34613</u>		29d. DATE SIGNED (Month, Day, Year) <u>Apr 22, 1995</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Steven Geller M.D. 9501 Old Annapolis Rd Ellicott City, MD 21042</u>							
31. DATE FILED (Month, Day, Year) <u>APR 25 1995</u>				32. REGISTRAR'S SIGNATURE <u>John Davidson Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14943

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Dominic Nicholas DeLuca</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 1, 1995</b>		3. TIME OF DEATH <b>12:08 A M</b>	
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) YRS. MONTHS DAYS <b>29</b>		7. DATE OF BIRTH (Month, Day, Year) <b>April 2, 1995</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Arundel Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Queen Anne's</b>		10c. CITY, TOWN OR LOCATION <b>Centreville</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>105 Whitby Lane</b>			
10f. ZIP CODE <b>21617</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>na</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Guido DeLuca, Jr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Kelly Ann Dahle</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Guido &amp; Kelly DeLuca, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P. O. Box 192, Wye Mills, Md. 21679</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>May 13, 1995</b> <b>St. Peter's Cath. Church Cemetery</b>		20c. LOCATION — City or Town, State <b>Queenstown Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Thomas K. Helfenbein</b>				22. NAME AND ADDRESS OF FACILITY <b>Tom Helfenbein Funeral Homes, P.A.</b> <b>106 Shamrock Rd., Chester, Md. 21619</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>BACTERIAL E. coli Meningitis + Encephalitis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>E. coli infection</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): <b>22 days</b>						Approximate Interval Between Onset and Death <b>22 days</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>N/A</b>	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examining and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Milton W. Werthmann Jr.</b>				29c. LICENSE NUMBER <b>D 114 97</b>		29d. DATE SIGNED (Month, Day, Year) <b>5-1-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Milton W. Werthmann Jr. 6306 EVERMAY DR. McLean VA 22101</b>							
31. DATE FILED (Month, Day, Year) <b>5-1-MAY 03 1995</b>				32. REGISTRAR'S SIGNATURE <b>Julia Anderson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14944

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CARLTON WILLIAM DAYTON				2. DATE OF DEATH MONTH 4 DAY 29 YEAR 95		3. TIME OF DEATH 0850 M	
4. SOCIAL SECURITY NUMBER 214-07-7184		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept 30 1906	
9a. FACILITY NAME (If not institution, give street and number) Dorchester General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cambridge		9c. COUNTY OF DEATH Dorchester	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Dorchester		10c. CITY, TOWN OR LOCATION Cambridge		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 403 Willis St.				10f. ZIP CODE 21613		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) waterman, shoe repairman		16b. KIND OF BUSINESS/INDUSTRY self employed			
17. FATHER'S NAME (First, Middle, Last) William Clarence Dayton				16. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Florence Adams			
19a. INFORMANT'S NAME (Type/Print) C. William Dayton Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Choptank Ave., Cambridge MD 21613			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dorchester Memorial Park 5/1		DATE 5/1		20c. LOCATION — City or Town, State Cambridge Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kenneth L. Spang</i>				22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St. Cambridge MD 21613			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Congestive Heart Failure</i> b. <i>Arteriosclerotic Cardiovascular disease with</i> c. <i>Atrial fibrillation</i> d. <i>Chronic Obstructive Lung Disease</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 7 days
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Eyup Tanman MD</i>				29c. LICENSE NUMBER D14349		29d. DATE SIGNED (Month, Day, Year) 4/29/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Eyup Tanman, M.D. 15 Franklin St., Cambridge MD 21613							
31. DATE FILED (Month, Day, Year) MAY 03 1995				32. REGISTRAR'S SIGNATURE <i>John A. Hurd</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

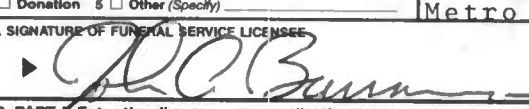
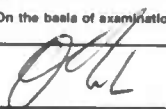
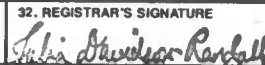
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>TERRANCE J. DRISCOLL</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>29</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>4:53p M</b>			
4. SOCIAL SECURITY NUMBER <b>406-75-7556</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>44</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9-3-50</b>		8. BIRTHPLACE (State or Foreign Country) <b>Ohio</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>605 OAKLAND HILL DRIVE APT. 202</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ARNOLD</b>				9c. COUNTY OF DEATH <b>ANNE ARUNDEL</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Arnold</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>805 Oakland Hills Drive</b>				10f. ZIP CODE <b>21012</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No-- If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE -- American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>4</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Roofer</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Construction</b>					
17. FATHER'S NAME (First, Middle, Last) <b>R. James Driscoll</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>L. Ruth McKinney</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Ruth Driscoll</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>488 Duressey Drive Severna Park, MD 21146</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. LOCATION -- City or Town, State <b>5/2 Catonsville, MD</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>495 Ritchie Hwy. Barranco FH Severna Park, MD 21146</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Gun shot wound to head (contact)</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>								Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <b>partial</b>	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>Fall 4-29-95</b>		28b. TIME OF INJURY <b>14 53 M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>Subject shot self.</b>	
		28e. PLACE OF INJURY -- At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>605 Oakland Hill Drive APT-202</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>O.C.M.E</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 30, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>									
31. DATE FILED (Month, Day, Year) <b>MAY 09 1995</b>		32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14946

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WALTER DAUGHUETY				2. DATE OF DEATH MONTH DAY YEAR APRIL 30, 1995		3. TIME OF DEATH 20:18 M	
4. SOCIAL SECURITY NUMBER 238-56-7392		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUNE 23 1940	
8. BIRTHPLACE (State or Foreign Country) NORTH CAROLINA				9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
9c. COUNTY OF DEATH				10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL	
10c. CITY, TOWN OR LOCATION MAYO				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER P.O. BOX 92	
10f. ZIP CODE 21106				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1958 - 1961				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) INSURANCE UNDERWRITER		16b. KIND OF BUSINESS/INDUSTRY HOME BENEFICIAL LIFE INS.CO.	
17. FATHER'S NAME (First, Middle, Last) RUSE DAUGHETY,				18. MOTHER'S NAME (First, Middle, Maiden Surname) FLOSSIE SHEPPARD			
19a. INFORMANT'S NAME (Type/Print) WALTER R. DAUGHETY, JR.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 92 MAYO, MARYLAND 21106			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) PINELAWN MEM. PARK 5/3/95		20c. LOCATION — City or Town, State KINSTON, NORTH CAROLINA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry A. Reese</i>				22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <u>cerebrovascular accident</u> 6 days							
b. <u>to tobacco abuse</u> 35 yrs							
c. _____							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Severe alcohol abuse</u> <u>coagulopathy</u>							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Monique M Canonico DO</i>				29c. LICENSE NUMBER Texas J2990		29d. DATE SIGNED (Month, Day, Year) 4/30/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Monique M Canonico DO JHHI Meyer 7 NCCU, Baltimore MD							
31. DATE FILED (Month, Day, Year) MAY 04 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14947

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Alan T. Dearstyn</b>				2. DATE OF DEATH MONTH <b>5</b> DAY <b>2</b> YEAR <b>95</b>		3. TIME OF DEATH <b>9:09 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>182-24-7043</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs., last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 26 1932</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Anne Arundel Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Lothian</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1140 Lower Pindell Road</b>				10f. ZIP CODE <b>20711</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1952-1954</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Horse Trainer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Thoroughbred Racing</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Lewis McAllen Dearstyn</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Grace Louise Marshall</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Grace L. Soskin</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12030 SE Plutus Ave/Hobe Sound/FL/33455</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		DATE <b>5/4</b>		20c. LOCATION — City or Town, State <b>Alexandria VA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>MSWagone</b>				22. NAME AND ADDRESS OF FACILITY <b>Advent Memorial Services Inc. Annapolis MD 21401</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>II. CARDIOPULMONARY ARREST</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Ischemic CARDIOMYOPATHY</b> DUE TO (OR AS A CONSEQUENCE OF): <b>H/O Colon Carcinoma</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Cholecystitis, Cholelithiasis, Pancreatitis</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dennis M. Hall</b>				29c. LICENSE NUMBER <b>MD 041216</b>		29d. DATE SIGNED (Month, Day, Year) <b>5-2-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dennis M. Hall 18 1204 W. St. Annapolis MD 21403</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 04 1995</b>				32. REGISTRAR'S SIGNATURE <b>Julia Swisher Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14948

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Bessie Mae Edney				2. DATE OF DEATH MONTH DAY YEAR April 22, 1995				3. TIME OF DEATH 1:40 A M	
4. SOCIAL SECURITY NUMBER 216-46-2265		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 24, 1901		8. BIRTHPLACE (State or Foreign Country) South Carolina	
9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park				9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Riverdale				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4704 Somerset Road				10f. ZIP CODE 20737		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 6 College (1-4 or 5+) 6				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Daniel Gallman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lisa Jane Poole					
19a. INFORMANT'S NAME (Type/Print) Dan Charles Edney				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4704 Somerset Road, Riverdale, MD 20737					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oakland Cemetery		DATE 4/27/95		20c. LOCATION — City or Town, State Gaffney, South Carolina			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.B. Geise</i>				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Asystole</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Atherosclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <i>15 minutes</i> <i>11</i> <i>10 yrs</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Senile Dementia</i> <i>Treated impetigo ; Decubitus Sacrum</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M.D.</i>				29c. LICENSE NUMBER D 22549		29d. DATE SIGNED (Month, Day, Year) 4-24-95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. G.M. Din, M.D. 6510 Kenilworth Ave., #2600, Riverdale, Maryland 20737									
31. DATE FILED (Month, Day, Year) APR 26 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14949

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Francis Carroll Elliott				2. DATE OF DEATH MONTH DAY YEAR April 28 1995		3. TIME OF DEATH 0538 M	
4. SOCIAL SECURITY NUMBER 214-30-7804		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 26, 1930	
9a. FACILITY NAME (If not institution, give street and number) Kent & Queen Anne's Hospital, Inc.,				9b. CITY, TOWN OR LOCATION OF DEATH Chestertown, Maryland		9c. COUNTY OF DEATH Kent County	
10a. STATE Maryland				10b. COUNTY Kent		10c. CITY, TOWN OR LOCATION Rock Hall	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 6053 N. Main Street			
10f. ZIP CODE 21661				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES 1949-1955		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Lineman/Maint.		16b. KIND OF BUSINESS/INDUSTRY General Motors Corp.			
17. FATHER'S NAME (First, Middle, Last) Clifton Aaron Elliott				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Eaton			
19a. INFORMANT'S NAME (Type/Print) Elizabeth C. Hoagland				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6053 N. Main St., Rock Hall, Md. 21661			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greensboro Cemetery May 1, 1995		20c. LOCATION — City or Town, State Greensboro, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE M. Keith Helfenbein				22. NAME AND ADDRESS OF FACILITY Tom Helfenbein Funeral Homes, P.A. 130 Speer Rd., Chestertown, Md.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. SUDDEN DEATH DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER E. F. Ciganek, M.D.				29c. LICENSE NUMBER D35048		29d. DATE SIGNED (Month, Day, Year) 5/1/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Eric F. Ciganek, MD; 109 S. Commerce St., Centreville, Md. 21617							
31. DATE FILED (Month, Day, Year) MAY 01 1995				32. REGISTRAR'S SIGNATURE John Anderson-Russell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

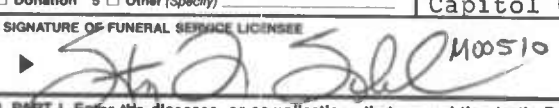
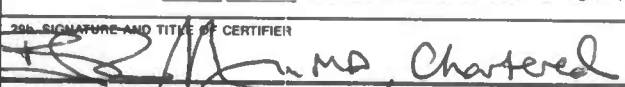
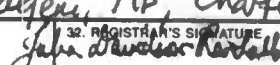




95 14950

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LYNN EDWARDS</b>				2. DATE OF DEATH MONTH <b>MAR.</b> DAY <b>31</b> YEAR <b>95</b>				3. TIME OF DEATH <b>0129</b> M	
4. SOCIAL SECURITY NUMBER <b>222-44-5910</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>38</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10/15/56</b>		8. BIRTHPLACE (State or Foreign Country) <b>Wilm., DE</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Suburban Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Bethesda</b>				9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Bethesda</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>10320 Westlake Dr., Apt. 403</b>				10f. ZIP CODE <b>20817</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Marketing Manager</b>		16b. KIND OF BUSINESS/INDUSTRY <b>IBM Computer</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Walter M. Edwards</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary M. Walker</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Walter M. Edwards</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>203 Stoney Run Rd., Wilmington, DE 19809</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Capitol Crematory 4/2/95</b>		20c. LOCATION — City or Town, State <b>Dover, DE</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Beeson Memorial Services 2053 Pulaski Hwy, Newark, DE 19702</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hepatorenal failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Alcoholism</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Depression</b> DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Sepsis</b>								Approximate Interval Between Onset and Death <b>5 days</b> <b>10 yrs</b> <b>10 yrs</b>	
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Chartered</b>		29c. LICENSE NUMBER <b>D42423</b>		29d. DATE SIGNED (Month, Day, Year) <b>03/31/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>B. Robert Mozafari, MA, Chartered, 9800 Falls Rd #104, Potomac, MD 20854</b>									
31. DATE FILED (Month, Day, Year) <b>MAY 16 1995</b>				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14951

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>William Thomas Evans II</i>				2. DATE OF DEATH MONTH <i>4</i> DAY <i>27</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>10: P M</i>	
4. SOCIAL SECURITY NUMBER <i>214-28-2197</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>65</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>5-19-1929</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>AT Home</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Marion</i>		9c. COUNTY OF DEATH <i>Somerset</i>	
10a. STATE <i>Md.</i>				10b. COUNTY <i>Somerset</i>		10c. CITY, TOWN OR LOCATION <i>Marion</i>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <i>P.O. Box 171</i>		10f. ZIP CODE <i>21838</i>	
10g. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College</i>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Laborer</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Truck Driver</i>			
17. FATHER'S NAME (First, Middle, Last) <i>William T. Evans II</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Beatrice B. Corbin</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Judy Evans</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>P.O. Box 171 Marion Md. 21838</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or other place) <i>St. Peter Cemetery 5-2-95</i>		20c. LOCATION — City or Town, State <i>Marion Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Anthony E. Ward</i>				22. NAME AND ADDRESS OF FACILITY <i>314 Cove St. Crisfield Md. 21817</i>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Metastatic Lung Cancer</i> Approximate Interval Between Onset and Death <i>3yrs.</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David C. Kerrigan, MD</i>				29c. LICENSE NUMBER <i>044688</i>		29d. DATE SIGNED (Month, Day, Year) <i>5/3/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>David C. Kerrigan, MD, Riverside Dr., Salisbury, MD 21801</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 04 1995</i>		32. REGISTRAR'S SIGNATURE <i>John Davidson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12-3-1944

95 14952

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ELLEN FITZHUGH</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>25</b> YEAR <b>95</b>		3. TIME OF DEATH <b>12PM</b>	
4. SOCIAL SECURITY NUMBER <b>223-05-4060</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>08-19-10</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>MARPLE CARE LARGO</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BOULDER RD UPPER MARBLE P.G.</b>		9c. COUNTY OF DEATH <b>P.G.</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George</b>		10c. CITY, TOWN OR LOCATION <b>Chapel Oaks</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1311 Farmingdale Avenue</b>				10f. ZIP CODE <b>20743</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>no</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>no</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Retired Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Charles Banks</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Maggie Williams</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Sadie Coates</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1406 Early Oaks Lane Chapel Oaks, Md.</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Maryland National Mem. Park 4/27/95</b>		20c. LOCATION — City or Town, State <b>Laurel Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>John T. Stewart IV</b>				22. NAME AND ADDRESS OF FACILITY <b>Stewart Funeral Home 4001 Benning Road, N.E.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebral Hemorrhage</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div> <b>Due to (or as a consequence of):</b>  <b>Normal Brain</b>  <b>Diabetic Mellitus</b> </div> <div> <b>Approximate Interval Between Onset and Death</b>  <b>6 months</b>  <b>1 yr</b>  <b>&gt; 5 yrs</b> </div> </div>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension, Barrett's Esophagus, Chronic GI bleed</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>John T. Stewart IV</b>				29c. LICENSE NUMBER <b>052261</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-25-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Richard J. Feigman MD 5700 Annapolis Rd N. Capitol</b>							
31. DATE FILED (Month, Day, Year) <b>APR 27 1995</b>		32. REGISTRAR'S SIGNATURE <b>John A. Davidson</b>					

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR



95 14953

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HELEN CHAFFINCH FLUHARTY</b>				2. DATE OF DEATH MONTH <b>04</b> DAY <b>07</b> YEAR <b>95</b>		3. TIME OF DEATH <b>11:20 P</b>	
4. SOCIAL SECURITY NUMBER <b>215-03-0120-A</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 12, 1910</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>William Hill Manor</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Easton</b>		9c. COUNTY OF DEATH <b>Talbot</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Queen Anne's</b>		10c. CITY, TOWN OR LOCATION <b>Stevensville</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>Box 16-5 Bay City</b>				10f. ZIP CODE <b>21666</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b> Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>John Emerson Chaffinch</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ida Mae Sutherland</b>			
19a. INFORMANT'S NAME (Type/Print) <b>David Bryant, Attny.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 838 Easton, Md. 21601</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Denton Cemetery</b>		20c. DATE <b>April 11, 1995</b>		20d. LOCATION — City or Town, State <b>Denton, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas K. Helfenbein</i>				22. NAME AND ADDRESS OF FACILITY <b>Tom Helfenbein Funeral Homes, P.A. 106 Shamrock Rd., Chester, Md. 21619</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lung Cancer (Adeno)</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <b>2 mos.</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pne IDDM Hypothyroidism</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. B. Buzze</i>				29c. LICENSE NUMBER <b>042816</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/10/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>607 Dutchmans Lane Easton MD</b>							
31. DATE FILED (Month, Day, Year) <b>APR 13 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julius Sanders-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DENNIS C. FOSTER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 06 95</b>		3. TIME OF DEATH <b>11:53A M</b>	
4. SOCIAL SECURITY NUMBER <b>219-48-3160</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>45 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>Sep. 29, 1949</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Washington, D.C.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>826 MAYO ROAD</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>EDGEWATER</b>	
9c. COUNTY OF DEATH <b>ANNE ARUNDEL</b>				RESIDENCE OF DECEDENT			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Queen Anne's</b>		10c. CITY, TOWN OR LOCATION <b>Chester</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1906 Cecil Court</b>				10f. ZIP CODE <b>21619</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Carpet Installer and Landscaping</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Carpet Landscaping</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Gilmer G. Foster</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Gertrude E. Fleming</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Irene Vanderhoof</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>147 E. Bayview Dr., Annapolis, Md. 21403</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Stevensville Cemetery April 9 1995</b>		20c. LOCATION — City or Town, State <b>Stevensville, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Thomas K. Helfenbein</b>				22. NAME AND ADDRESS OF FACILITY <b>Tom Helfenbein Funeral Homes, P.A. 106 Shamrock Rd., Chester, Md. 21619</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIAC TAMPONADE</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
a. <b>RUPURED DISSECTING AORTISM OF THE AORTA</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Harvey A. Gule</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 07/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Myra Ann A. Kosa Mrs. 111 PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>APR 10 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Sanders-Rudell</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14955

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Mary A. Falise</i>						2. DATE OF DEATH MONTH <i>4</i> DAY <i>18</i> YEAR <i>'95</i>		3. TIME OF DEATH <i>11:25P</i>	
4. SOCIAL SECURITY NUMBER <i>220-46-6460</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>82</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>7-02-1913</i>		8. BIRTHPLACE (State or Foreign Country) <i>Arkansas</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>320 Magothy Road</i>						9b. CITY, TOWN OR LOCATION OF DEATH <i>Severna Park</i>		9c. COUNTY OF DEATH <i>Anne Arundel</i>	
10a. STATE <i>MD</i>		10b. COUNTY <i>Anne Arundel</i>		10c. CITY, TOWN OR LOCATION <i>Severna Park</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <i>320 Magothy Rd</i>						10f. ZIP CODE <i>21146</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Caucasian</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Home</i>					
17. FATHER'S NAME (First, Middle, Last) <i>Vincent Liberto</i>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Concetta Centineo</i>			
19a. INFORMANT'S NAME (Type/Print) <i>JO ANNE FALISE</i>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>Same as #10</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>NEW CATHEDRAL CEM. 4/22/95</i>		20c. LOCATION — City or Town, State <i>Baltimore, MD</i>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>						22. NAME AND ADDRESS OF FACILITY <i>BARRANCO and Sons Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Chronic General total Physical</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>deterioration due to</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Parkinson's disease</i> DUE TO (OR AS A CONSEQUENCE OF): <i>years</i>						Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER <i>D11653</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/26/95</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Peter F. VERKOW MD 1833 Forest Dr Annapolis MD</i>									
31. DATE FILED (Month, Day, Year) <i>MAY 09 1995</i>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 14956

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY FOXWELL</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>6</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>8:45A</b> M	
4. SOCIAL SECURITY NUMBER <b>578-05-8980</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec 27 1916</b>		8. BIRTHPLACE (State or Foreign Country) <b>Washington, D.C.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Meridian Health Care Center/Spa Creek</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>				9c. COUNTY OF DEATH <b>Anne Arundel</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Annapolis</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>35 Milkshake Lane</b>				10f. ZIP CODE <b>21403</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (14 or 5+) _____		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Montgomery Cornwell</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Emma Wallingsford</b>					
19a. INFORMANT'S NAME (Type/Print) <b>David M. Foxwell</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>300 Beach Drive Annapolis, MD 21403</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hillcrest Cemetery 5/10/95</b>		20c. LOCATION — City or Town, State <b>Annapolis, Maryland</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald A. Taylor</i>			
22. NAME AND ADDRESS OF FACILITY <b>John M. Taylor Funeral Home</b>		147 Duke of Gloucester St. Annapolis, MD							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sudden Death</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Coronary Artery Disease</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								Approximate interval Between Onset and Death <b>instantaneous</b> <b>years</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Status Post Stroke</b> <b>Chronic Renal Failure</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Peter Verkow</i>				29c. LICENSE NUMBER <b>D10653</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/6/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Peter Verkow, M.D. 1833-A Forest Drive Annapolis, MD 21401</b>									
31. DATE FILED (Month, Day, Year) <b>MAY 08 1995</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 14957

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Elizabeth Farrell				2. DATE OF DEATH MONTH DAY YEAR May 4 1995		3. TIME OF DEATH 6:15A M	
4. SOCIAL SECURITY NUMBER 214-30-6808		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec 15 1909	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Meridian Health Care Center/Spa Creek		9b. CITY, TOWN OR LOCATION OF DEATH Annapolis	
9c. COUNTY OF DEATH Anne Arundel				10a. STATE MD		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Annapolis				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 320 Riverview Avenue	
10f. ZIP CODE 21403				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Home	
17. FATHER'S NAME (First, Middle, Last) Charles Henry Leitch				18. MOTHER'S NAME (First, Middle, Maiden Surname) Vida E. Childs			
19a. INFORMANT'S NAME (Type/Print) C. Fay Farrell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 320 Riverview Avenue Annapolis, MD 21403			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hillcrest Cemetery 5/8/95		20c. LOCATION — City or Town, State Annapolis, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald A. Taylor</i>				22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Enter only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ii. <i>Arterial Occlusion, left lower extremity 2 days</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Alzheimer's Syndrome</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard I. Hochman</i>				29c. LICENSE NUMBER D05192		29d. DATE SIGNED (Month, Day, Year) May 5, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard I. Hochman, M.D. 16 Murray Avenue Annapolis, MD 21401 (410-268-7576)							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14958

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Richard Joseph Farrall</i>				2. DATE OF DEATH MONTH <i>4</i> DAY <i>29</i> YEAR <i>95</i>		3. TIME OF DEATH <i>7:30 P M</i>	
4. SOCIAL SECURITY NUMBER <i>211-12-2236</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>69</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>April 16 1926</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Pennsylvania</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Anne Arundel Medical Center</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Annapolis</i>	
9c. COUNTY OF DEATH <i>Anne Arundel</i>				10a. STATE <i>MD</i>		10b. COUNTY <i>Anne Arundel</i>	
10c. CITY, TOWN OR LOCATION <i>Severna Park</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>212 McKeon Drive</i>	
10f. ZIP CODE <i>21146</i>				10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>WWII</i>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i> College (1-4 or 5+) <i>4</i>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Builder/Developer</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Real Estate</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Joseph Farrall</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary O'Boyle</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Janet I. Farrall</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>212 McKeon Drive Severna Park, Maryland 21146</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Ft. Lincoln Crematory 5/1/95</i>			
20c. LOCATION — City or Town, State <i>Brentwood, Maryland</i>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John M. Taylor</i>			
22. NAME AND ADDRESS OF FACILITY <i>John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD</i>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Metastatic Rectal Cancer</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
26. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <i>M</i>			
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Enser W. Cole, III M.D.</i>			
29c. LICENSE NUMBER <i>016354</i>				29d. DATE SIGNED (Month, Day, Year) <i>5/1/95</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Enser W. Cole, III, M.D. 900 Bestgate Rd. Annapolis, MD 21401 (410-573-5300)</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 02 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 14959

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Pauline Fields				2. DATE OF DEATH MONTH DAY YEAR April 26, 1995				3. TIME OF DEATH 8:03 p. M	
4. SOCIAL SECURITY NUMBER 214-34-6120		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1-30-1934		8. BIRTHPLACE (State or Foreign Country) FLA.	
9a. FACILITY NAME (If not institution, give street and number) Edw. W. McCready Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Crisfield				9c. COUNTY OF DEATH Somerset	
RESIDENCE OF DECEDENT									
10a. STATE Md		10b. COUNTY SOMERSET		10c. CITY, TOWN OR LOCATION Crisfield				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 114 Md. Ave.				10f. ZIP CODE 21817		10g. CITIZEN OF WHAT COUNTRY? U.S.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		16b. KIND OF BUSINESS/INDUSTRY Robberset Co. Sea Food Brush Maker			
17. FATHER'S NAME (First, Middle, Last) Abel Russ				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Timms					
19a. INFORMANT'S NAME (Type/Print) Alfred Fields				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 114 Md. Ave Crisfield Md. 21817					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cottage Grove Cemetery 5/1/95		20c. LOCATION — City or Town, State Westover Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Anthony C. Ward				22. NAME AND ADDRESS OF FACILITY 314 Cove St. Crisfield Md. 21817					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) →									
a. Acute Myocardial Infarction									
b. Hypertension									
c. Insulin Dependent Diabetes Mellitus									
d.									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER M.D.				29c. LICENSE NUMBER D 29987		29d. DATE SIGNED (Month, Day, Year) 4-27-95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Albert Dacanay, McCready Hospital, Crisfield, Md. 21817									
31. DATE FILED (Month, Day, Year) MAY 04 1995				32. REGISTRAR'S SIGNATURE					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Submitted by: 2021-2022

95 14960

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FRANK JOSEPH GRECO</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 2 1995</b>		3. TIME OF DEATH <b>23:55 M</b>	
4. SOCIAL SECURITY NUMBER <b>212-12-8422</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>81 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>March 9 1914</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND, MD</b>	
9c. COUNTY OF DEATH <b>ALLEGANY</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Allegany</b>	
10c. CITY, TOWN OR LOCATION <b>Frostburg</b>				10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>		10e. STREET AND NUMBER <b>39 N. Water Street</b>	
10f. ZIP CODE <b>21532</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES <b>W.W.II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>				16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Barber</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Business</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Joseph Greco</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rose Marie Biscaglia</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Patricia Horner</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>39 N. Water Street Frostburg, Maryland 21532</b>			
20a. METHOD OF DISPOSITION <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Michaels Cemetery May 5, 95</b>		20c. LOCATION — City or Town, State <b>Frostburg, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John R. Durst</i>				22. NAME AND ADDRESS OF FACILITY <b>Durst Funeral Home 57 Frost Avenue Frostburg, Md. 21532</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CARDIAC DYSFUNCTION - CARDIOMYOPATHY</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. CORONARY ARTERY DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Diffuse Atherosclerosis</b> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>12 months</b> <b>25 years</b> <b>Unknown</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>End Stage Renal Disease, Valvular Heart Disease</b>							
24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>					
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert Welik</i>				29c. LICENSE NUMBER <b>D31875</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 3/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. ROBERT WELIK, M.D., 902 SETON DRIVE, CUMBERLAND, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 04 1995</b>				32. REGISTRAR'S SIGNATURE <i>John R. Durst</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


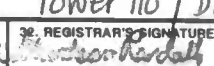
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14961

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BARBARA GRIM</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 29 1995</b>				3. TIME OF DEATH p.m. <b>1:03</b>	
4. SOCIAL SECURITY NUMBER <b>213-44-6556</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>70</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS <b>70</b>		IF UNDER 24 HRS. HOURS MIN. <b>70</b>		7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 16, 1925</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Maryland</b>				10b. COUNTY <b>Allegany</b>	
10c. CITY, TOWN OR LOCATION <b>Frostburg</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>8 Frost Ave.</b>	
10f. ZIP CODE <b>21532</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John E. Enterline</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Charlotte Bates</b>				19a. INFORMANT'S NAME (Type/Print) <b>Carole Mc Cormick</b>	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8 Frost Ave., Frostburg, Md. 21532</b>				20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Frostburg Memorial Park 5/2</b>	
20c. LOCATION — City or Town, State <b>Frostburg, Maryland</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>57 Frost Ave. Durst Funeral Home, Frostburg, Md. 21532</b>	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Severe aspiration pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Probable leukencephalopathy</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Radiation therapy</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Lung cancer</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST				Approximate Interval Between Onset and Death <b>4 Days</b> <b>8-12 mos.</b> <b>3 yrs.</b> <b>3 yrs.</b>				PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Sherita A. Hill MD Housestaff</b>				29c. LICENSE NUMBER <b>M6279</b>				29d. DATE SIGNED (Month, Day, Year) <b>4/29/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Sherita A. Hill Tower 110 Doctor's Lounge/JHH/Balt, MD 21287</b>				31. DATE FILED (Month, Day, Year) <b>MAY 03 1995</b>				32. REGISTRAR'S SIGNATURE 	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 687600

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14962

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN O. GETTY				2. DATE OF DEATH MONTH DAY YEAR APRIL 30 1995		3. TIME OF DEATH 7:00 A M	
4. SOCIAL SECURITY NUMBER 219-14-5101		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 20, 1924	
8. BIRTHPLACE (State or Foreign Country) Md				9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Cumberland	
9c. COUNTY OF DEATH Allegany				10a. STATE Maryland		10b. COUNTY Allegany	
10c. CITY, TOWN OR LOCATION Lonaconing				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 80 East Main Street	
10f. ZIP CODE 21539				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Broker		16b. KIND OF BUSINESS/INDUSTRY Sales	
17. FATHER'S NAME (First, Middle, Last) Gorman E. Getty Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Verna Schuyler			
19a. INFORMANT'S NAME (Type/Print) Jean Getty				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 80 E. Main St., Lonaconing, Md. 21539			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cumberland Crematory April 30, 1995		20c. LOCATION — City or Town, State Cumberland, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James E. McKenzie</i>				22. NAME AND ADDRESS OF FACILITY Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gangrene of Bowel DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 1 Day
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Johnston (Gupte)</i>		29c. LICENSE NUMBER D 36766		29d. DATE SIGNED (Month, Day, Year) April 30, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VIK POONAI M.D., 955 FREDERICK STREET, CUMBERLAND, MD 21502							
31. DATE FILED (Month, Day, Year) MAY 01 1995		32. REGISTRAR'S SIGNATURE <i>Johnston</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14963

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DARREN C. GORDON</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>21</b> YEAR <b>95</b>		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER <b>052-74-0043</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>15</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>11-26-79</b>	
8. BIRTHPLACE (State or Foreign Country) <b>U.S.A.</b>				9. COUNTY OF DEATH <b>N/A</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>UMMS University of Maryland Med System</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTO, Baltimore City</b>			
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Upper Marlboro</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>12103 Old Colony Drive</b>		10f. ZIP CODE <b>20772</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>Student</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Student</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Robert L. Gordon</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary L. Mears</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Robert L. Gordon</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12103 Old Colony Dr., Upper Marlboro, Md. 20772</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory 4/23/95 Alexandria, Va.</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George P. Kalas</i>				22. NAME AND ADDRESS OF FACILITY <b>George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Anoxic Encephalopathy</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Cardiac Arrest Secondary to hypoxia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Adult Respiratory Distress Syndrome</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  <b>Mild Acute Renal Failure</b>						Approximate Interval Between Onset and Death <b>10 hrs</b> <b>10 hrs</b> <b>1 month</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Mild Acute Renal Failure</b>						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Neal Reemala MD</i>				29c. LICENSE NUMBER <b>D 27163</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/21/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Shock Trauma Center, 22 S. Greene St. Balto MD</b>							
31. DATE FILED (Month, Day, Year) <b>APR 24 1995</b>				32. REGISTRAR'S SIGNATURE <i>Julia Ann... Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95-1915-003  
blh

95 14964

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>Kevin Michael Gallagher</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 03 1995</b>		3. TIME OF DEATH <b>2245</b> M	
4. SOCIAL SECURITY NUMBER <b>579-78-1704</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>38</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 24, 1956</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Anne Arundel General Hospital</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>		8c. COUNTY OF DEATH <b>Anne Arundel</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Deale</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5949 Sneed Drive</b>				10f. ZIP CODE <b>20751</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Contractor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Self-Employed</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Bernard W. Gallagher</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary C. Ford</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Lori Gallagher</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5949 Sneed Drive, Deale, Maryland 20751</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory 04/07/95</b>		20c. LOCATION — City or Town, State <b>Alexandria, Virginia</b>		22. NAME AND ADDRESS OF FACILITY <b>Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Constance Gasch</i>				22. NAME AND ADDRESS OF FACILITY <b>Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. HEAD &amp; NECK INJURIES</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>4/3/95</b>		28b. TIME OF INJURY <b>2127P</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED <b>STONE THROWN AT WINDSHIELD OF VEHICLE</b>		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>RT 262 &amp; 268 DEAL, MD</b>			
29a. CERTIFIER 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mario F. Golue Jr</i> <b>MARIO F. GOLUE JR MD</b>							
29c. LICENSE NUMBER <b>O.C..M.E.</b>				29d. DATE SIGNED (Month, Day, Year) <b>April 05 1995</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GOLUE JR MD 111 Penn Street, Baltimore Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>APR 07 1995</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CLAUDE GILREATH</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>22</b> YEAR <b>1995</b>				3. TIME OF DEATH <b>1:30PM</b> M	
4. SOCIAL SECURITY NUMBER <b>217-58-4273</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>43</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7. DATE OF BIRTH (Month, Day, Year) <b>12/04/51</b>				8. BIRTHPLACE (State or Foreign Country) <b>Anne Arundel Co. Md.</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>PRINCE GEORGES' COMMUNITY HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CHEVERLY</b>				9c. COUNTY OF DEATH <b>Prince Georges'</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>PG</b>				10c. CITY, TOWN OR LOCATION <b>Landover</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>7800 Suiter Way</b>				10f. ZIP CODE <b>20785</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+) <b>Truck Driver</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Truck Driver</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Silver Hill Concrete Co.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Elmer T. Gilreath</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ernestine Wells</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Marsha H. Gilreath/wife</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2700 Second St., SE Wash., DC 20032</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Annapolis Memorial Garden</b>				20c. LOCATION — City or Town, State <b>Annapolis, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> #866				22. NAME AND ADDRESS OF FACILITY <b>Robert G. Mason Funeral Home, Inc.</b> <b>1661 Good Hope Road, S.E. Wash., DC 20020</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>AIDS</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST A. DUE TO (OR AS A CONSEQUENCE OF): B. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): D. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>4M</b>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D41978</b>				29d. DATE SIGNED (Month, Day, Year) <b>4-24-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Nader JavaKolim-D. PGH.</b>									
31. DATE FILED (Month, Day, Year) <b>APR 28 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					





95 14966

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Charlotte E. Gleason				2. DATE OF DEATH MONTH DAY YEAR April 19, 1995		3. TIME OF DEATH 7:02 P.M. M	
4. SOCIAL SECURITY NUMBER 577-10-5365		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 20, 1908	
9a. FACILITY NAME (If not institution, give street and number) Doctors' Community Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Lanham		9c. COUNTY OF DEATH Prince George's	
10a. STATE Maryland				10b. COUNTY		10c. CITY, TOWN OR LOCATION Huntingtown	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 3134 Hollan Cliff Rd.				10f. ZIP CODE 20639		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 8 College (1-4 or 5+) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waitress		16b. KIND OF BUSINESS/INDUSTRY Restaurant			
17. FATHER'S NAME (First, Middle, Last) Unavailable				18. MOTHER'S NAME (First, Middle, Maiden Surname) Unavailable			
19a. INFORMANT'S NAME (Type/Print) Dorothy B. Lewis				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as # 10.			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory		DATE 4/22		20c. LOCATION — City or Town, State Alexandria, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans Pres				22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Road Bowie Maryland 20715			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory arrest 2° to pneumonia DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death 1 week.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Roultan Farahi M.D.				29c. LICENSE NUMBER D 43446		29d. DATE SIGNED (Month, Day, Year) 4-21-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROULTAN FARAH-FAR 4000 Mitchellville Road B216 Bowie MD 20716							
31. DATE FILED (Month, Day, Year) APR 28 1995				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14967

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) DARRYL GREENE				2. DATE OF DEATH april 19 95		3. TIME OF DEATH 11:00A M	
4. SOCIAL SECURITY NUMBER 579-88-0979		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 24 YRS.	7. DATE OF BIRTH (Month, Day, Year) October 19, 1970		8. BIRTHPLACE (State or Foreign Country) Washington, D.C.	
9a. FACILITY NAME (If not institution, give street and number) GRASS AREA OF WHEELER HILL RD.				9b. CITY, TOWN OR LOCATION OF DEATH OXON HILL		9c. COUNTY OF DEATH PRINCE GEORGES	
RESIDENCE OF DECEDENT							
10a. STATE D.C.		10b. COUNTY		10c. CITY, TOWN OR LOCATION Washington		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3504 Minnesota Avenue, N.E. Apt. #3				10f. ZIP CODE 20019		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unemployed		16b. KIND OF BUSINESS/INDUSTRY N/A			
17. FATHER'S NAME (First, Middle, Last) Isaac F. Greene				18. MOTHER'S NAME (First, Middle, Maiden Surname) Christine Bennett			
19a. INFORMANT'S NAME (Type/Print) Christine B. Clark (Mother)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 Eagle Tavern Drive Garner, North Carolina 27529			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) National Harmony Memorial Park 4/26/95		20c. LOCATION — City or Town, State Landover, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Gun Shot Wounds DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) GRASS AREA					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 4-19-95		28b. TIME OF INJURY 18:45 M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED Subject shot		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) Wheeler Hill Rd			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) APRIL 21/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R Fowler 111 PENN STREET, BALTIMORE, MARYLAND 21201							
31. DATE FILED (Month, Day, Year) APR 27 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14968

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert Eugene Gossman				2. DATE OF DEATH MONTH DAY YEAR April 22 1995		3. TIME OF DEATH 11:15 A M	
4. SOCIAL SECURITY NUMBER 275-14-6788		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 28, 1919	
8. BIRTHPLACE (State or Foreign Country) Ohio				9. FACILITY NAME (If not institution, give street and number) Memorial Hospital		10. CITY, TOWN OR LOCATION OF DEATH Easton	
11. RESIDENCE OF DECEDENT				12. COUNTY Queen Anne's		13. CITY, TOWN OR LOCATION Grasonville	
14. STATE Maryland		15. STREET AND NUMBER 205 Perry Corner Road		16. ZIP CODE 21638		17. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		19. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		21. RACE — American Indian, Black, White, etc. Specify: White	
22. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 7		23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Aircraft Mechanic & Consultant		24. KIND OF BUSINESS/INDUSTRY Rockwell Int.			
25. FATHER'S NAME (First, Middle, Last) Charles Gossman				26. MOTHER'S NAME (First, Middle, Maiden Surname) Mable Blosser			
27. INFORMANT'S NAME (Type/Print) Mrs. Joan Harrell				28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 505 Grasonville, Md. 21638			
29. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory April 24, 1995		31. LOCATION — City or Town, State Baltimore, Md.		32. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas K. Helfenbein	
33. NAME AND ADDRESS OF FACILITY Tom Helfenbein Funeral Homes, P.A. 106 Shamrock Rd., Chester, Md. 21619		34. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Bronchogenic lung cancer</u> b. c. d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					
35. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						36. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
37. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						38. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
39. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		40. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
41. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		42. DATE OF INJURY (Month, Day, Year)		43. TIME OF INJURY M		44. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
45. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		46. DESCRIBE HOW INJURY OCCURED					
47. LOCATION (Street and Number or Rural Route Number, City or Town, State)		48. 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
49. SIGNATURE AND TITLE OF CERTIFIER Lawrence D. Bohan M		50. LICENSE NUMBER D 27409		51. DATE SIGNED (Month, Day, Year) 4.23.95			
52. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Lawrence D. Bohan 606 Dutchman's Lane, Easton, Maryland 21601							
53. DATE FILED (Month, Day, Year) APR 25 1995		54. REGISTRAR'S SIGNATURE John D. Anderson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 8 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14969

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Elizabeth Daily Gaeng</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Apr. 1, 1995</b>		3. TIME OF DEATH <b>9:15 p. M</b>	
4. SOCIAL SECURITY NUMBER <b>216-10-2245</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 2, 1912</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Meredian Nursing Center Corsica Hills</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Centreville</b>		8c. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. STATE <b>Maryland</b>		9b. COUNTY <b>Queen Anne's</b>		9c. CITY, TOWN OR LOCATION <b>Chester</b>		9d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10a. STREET AND NUMBER <b>1771 Harbor Drive</b>				10b. ZIP CODE <b>21619</b>		10c. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Clerk</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>State Social Services</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John Carroll Daily</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Loretta Bachelor</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Betty Jean Hull</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1771 Harbor Drive, Chester, Md. 21619</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Stevensville Cemetery</b>		20c. DATE <b>April 5, 1995</b>		20d. LOCATION — City or Town, State <b>Stevensville, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas K. Helfenbein</i>				22. NAME AND ADDRESS OF FACILITY <b>Tom Helfenbein Funeral Homes, P.A. 106 Shamrock Road, Chester, Md. 21619</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>STROKE</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>DYSPLASIA</b> DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify):					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE NOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Eric F. Ciganek, MD</i>				29c. LICENSE NUMBER <b>D35043</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/4/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Eric F. Ciganek, MD. 109 S. Commerce St., Centreville, Md. 21617</b>							
31. DATE FILED (Month, Day, Year) <b>APR 04 1995</b>				32. REGISTRAR'S SIGNATURE <i>John T. Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Bernard Roy Green</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 3 95</b>		3. TIME OF DEATH <b>2:35 A M</b>	
4. SOCIAL SECURITY NUMBER <b>226-40-9066</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>58</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 1, 1936</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>		9c. COUNTY OF DEATH <b>Frederick</b>	
10a. STATE <b>W. Va.</b>				10b. COUNTY <b>Jefferson</b>		10c. CITY, TOWN OR LOCATION <b>Ranson</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>Appletree Gardens Building 102 Apt. 104</b>				10f. ZIP CODE <b>25438</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S. of A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Negro</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Groom</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Racetrack</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Alexandre Hamilton Green</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Hattie Rust</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Alex Green</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>226 Meadows Lane N.E., Leesburg, Virginia 22075</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gleedsville Cemetery 5-10-95</b>		20c. LOCATION — City or Town, State <b>near Leesburg, Virginia</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wm J. McInnis</i>				22. NAME AND ADDRESS OF FACILITY <b>Loudoun Funeral Chapel P.O. Box 1316, Leesburg, Virginia 22075</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Intracerebral Hemorrhage</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>STATUS Epilepticus</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Barbara J. [Signature]</i>				29c. LICENSE NUMBER <b>H45306</b>		29d. DATE SIGNED (Month, Day, Year) <b>5-3-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>801 Tow House Ave Bldg H6 Frederick MD 21701</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 15 1995</b>				32. REGISTRAR'S SIGNATURE <i>John [Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-724 6/8/95 t.t

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LARRY C. HACKETT</b>				2. DATE OF DEATH MONTH <b>04</b> DAY <b>14</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>0447 A M</b>	
4. SOCIAL SECURITY NUMBER <b>579-70-9503</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>41</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 30, 1954</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Wash., D.C.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>3508 WINSTON STREET</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>OXON HILL</b>	
9c. COUNTY OF DEATH <b>PRINCE GEORGES</b>				10a. STATE <b>D.C.</b>		10b. COUNTY <b>N/A</b>	
10c. CITY, TOWN OR LOCATION <b>Washington</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>4503- 7th Street, N.E.</b>	
10f. ZIP CODE <b>20017</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1</b> College (1-4 or 5+) <b>1</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Police Officer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Sterling W. Hackett, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Garlene Cotton</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Catherine M. Hackett</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4503- 7th St., NE Wash., DC 20017</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lincoln Memorial Cemetery 4/19</b>		20c. LOCATION — City or Town, State <b>Suitland, MD.</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Melita W. Hackett</i>	
22. NAME AND ADDRESS OF FACILITY <b>Hackett's Funeral Chapel, Inc. 814- Upshur Street, N.W.</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SMOKE INHALATION AND THERMAL INJURIES</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined					
28a. DATE OF INJURY (Month, Day, Year) <b>4-14-95</b>		28b. TIME OF INJURY <b>2:56 AM</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED SUBJECT FOUND <b>INSIDE CAR THAT HAD CAUGHT FIRE</b>	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>CAR</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>3500 BLK. WINSTON ST. OXON HILL, MARYLAND</b>					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Deanna J. Clarke</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 14, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>111 Penn Street, Baltimore, Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>APR 26 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson Ricketts</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

2

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14972

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Norma Hanback</b>				2. DATE OF DEATH MONTH <b>April</b> DAY <b>20</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>1002 PM</b>	
4. SOCIAL SECURITY NUMBER <b>579-14-7876</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>80</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	7. DATE OF BIRTH (Month, Day, Year) <b>April 16, 1915</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Washington, DC</b>				9a. FACILITY NAME (If not institution, give street and number) <b>North Arundel Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Glen Burnie</b>	
9c. COUNTY OF DEATH <b>Anne Arundel</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>	
10c. CITY, TOWN OR LOCATION <b>Kettering</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>12114 Blaketon Street</b>	
10f. ZIP CODE <b>20772</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Beautician</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Beauty Salons</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Frank Barnes</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sadie Kramer</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Thomas F. Bartholomew</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12114 Blaketon Street, Kettering, Maryland 20772</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery 04/22/95</b>		20c. LOCATION — City or Town, State <b>Brentwood, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>W.B. Grewier</b>				22. NAME AND ADDRESS OF FACILITY <b>Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MYOCARDIAL INFARCTION</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
I. <b>ACUTE PULMONARY EDEMA</b> <b>15 DAYS</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
II. <b>PNEUMONIA</b> <b>7 DAYS</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
III. <b>BRAIN STEM CEREBROVASCULAR ACCIDENT</b> <b>7 DAYS</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dan Heller Schreibeler MD</b>				29c. LICENSE NUMBER <b>D28221</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 20, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DAN Heller Schreibeler, MD 301 Hospital Drive, Glen Burnie, Maryland</b>							
31. DATE FILED (Month, Day, Year) <b>APR 24 1995</b>				32. REGISTRAR'S SIGNATURE <b>Jane Davidson-Kardall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DAVID WARREN HARRISON</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 18 1995</b>		3. TIME OF DEATH <b>9:46P</b>	
4. SOCIAL SECURITY NUMBER <b>214-42-4868</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>52</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 29, 1942</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Washington, DC</b>				9a. FACILITY NAME (If not institution, give street and number) <b>HOWARD COUNTY GENERAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Columbia</b>	
9c. COUNTY OF DEATH <b>HOWARD</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Howard</b>	
10c. CITY, TOWN OR LOCATION <b>Columbia</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>11224A Avalanche Way</b>	
10f. ZIP CODE <b>21044</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Sales Representative</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Insurance Company</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John Rodman Harrison</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ruth Smith</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ruth Harrison</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3905 Stoconga Drive, Beltsville, Maryland 20705</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery 04/24/95</b>		20c. LOCATION — City or Town, State <b>Brentwood, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>W.B. Greiner</b>				22. NAME AND ADDRESS OF FACILITY <b>Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>J. A. Locke MD</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 19 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. A. Locke, MD 111 Penn Street, Baltimore, Maryland 21201.</b>							
31. DATE FILED (Month, Day, Year) <b>APR 24 1995</b>				32. REGISTRAR'S SIGNATURE <b>J. A. Locke</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LEONARD (NMN) HAMMILL				2. DATE OF DEATH MONTH DAY YEAR April 19, 1995		3. TIME OF DEATH 4:00 A M	
4. SOCIAL SECURITY NUMBER 578-12-9358		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 24, 1911	
9a. FACILITY NAME (If not institution, give street and number) Magnolia Gardens				9b. CITY, TOWN OR LOCATION OF DEATH Lanham		9c. COUNTY OF DEATH Prince George's	
10a. STATE Maryland				10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Hyattsville	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 6700 Belcrest Road - Apt. #529				10f. ZIP CODE 20782		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (14 or 5+) 5		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cable Splicer		16b. KIND OF BUSINESS/INDUSTRY United States Navy Yard			
17. FATHER'S NAME (First, Middle, Last) Machen Kyle Hammill				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Elizabeth Jones			
19a. INFORMANT'S NAME (Type/Print) Sarah Frances Hammill				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6700 Belcrest Road, Apt. #529, Hyattsville, MD 20782			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 04/22/95		20c. LOCATION — City or Town, State Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.B. G...</i>				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Metastatic Bronchogenic Carcinoma</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Chronic Obstructive Pulmonary Disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary Artery Disease</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>James Steinberg MD</i>		29c. LICENSE NUMBER D12015		29d. DATE SIGNED (Month, Day, Year) 4/21/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Louis E. Steinberg 6492 Landover Road, Landover, Maryland 20785-1451							
31. DATE FILED (Month, Day, Year) APR 24 1995		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROKISHA TOMIKA HOPKINS				2. DATE OF DEATH MONTH DAY YEAR April 21 1995		3. TIME OF DEATH 3:44P M					
4. SOCIAL SECURITY NUMBER 217-43-4156		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS HOURS MIN. 2 13		7. DATE OF BIRTH (Month, Day, Year) FEB. 8, 1995		8. BIRTHPLACE (State or Foreign Country) CHEVERLY, MD			
9a. FACILITY NAME (If not Institution, give street and number) DOCTORS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH LANHAM			9c. COUNTY OF DEATH PRINCE GEORGES				
10a. STATE MARYLAND				10b. COUNTY PRINCE GEORGE'S		10c. CITY, TOWN OR LOCATION NEW CARROLLTON		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 7855 RIVERDALE ROAD #202				10f. ZIP CODE 20784		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A		16b. KIND OF BUSINESS/INDUSTRY N/A							
17. FATHER'S NAME (First, Middle, Last) JEROME RAZOR				18. MOTHER'S NAME (First, Middle, Maiden Surname) KIM LYNCH							
19a. INFORMANT'S NAME (Type/Print) KIM HOPKINS/ MOTHER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7855 RIVERDALE RD. #202 NEW CARROLLTON, MD 20784							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HARMONY MEMORIAL PARK 4-29		20c. LOCATION — City or Town, State LANDOVER, MARYLAND							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Shawana L. Braxton</i>				22. NAME AND ADDRESS OF FACILITY J.B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MD 20785							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SUDDEN INFANT DEATH SYNDROME DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> XER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King M.D.</i>						29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) APRIL 27, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING M.D. 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) APR 28 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


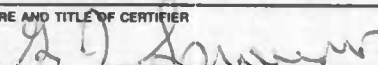
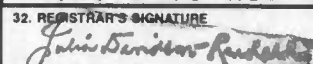
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14976

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Bernard Wayne Horney</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 18, 1995</b>		3. TIME OF DEATH M <b>12:50A</b>	
4. SOCIAL SECURITY NUMBER <b>220-26-8875</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>64</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 27, 1930</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>100 Old Love Point Road</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Stevensville</b>	
9c. COUNTY OF DEATH <b>Queen Anne's</b>				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>Queen Anne's</b>		10c. CITY, TOWN OR LOCATION <b>Chester</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>Stevensville Village Apts. #303</b>	
10f. ZIP CODE <b>21619</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1951-1953 Korea</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>8</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Maintenance Supv.</b>	
16b. KIND OF BUSINESS/INDUSTRY <b>Md. Trans. Auth. (Bay Bridge)</b>		17. FATHER'S NAME (First, Middle, Last) <b>Charles Patrick Horney</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ann Marie Hess</b>		19a. INFORMANT'S NAME (Type/Print) <b>Lisa A. Dorrell</b>	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 23; Grasonville, Md. 21638</b>		20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Tom Helfenbein Funeral Homes, P.A. 106 Shamrock Rd., Chester, Md. 21619</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. Lung Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>c. COPD</b>		Approximate Interval Between Onset and Death <b>1 yr</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>032036</b>	
29d. DATE SIGNED (Month, Day, Year) <b>Apr. 18, 1995</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Gary J. Sprouse, M.D. 2108 Red Apple Plaza, Chester, Md. 21619</b>		31. DATE FILED (Month, Day, Year) <b>APR 19 1995</b>		32. REGISTRAR'S SIGNATURE 	

TO BE COMPLETED BY FUNERAL DIRECTOR

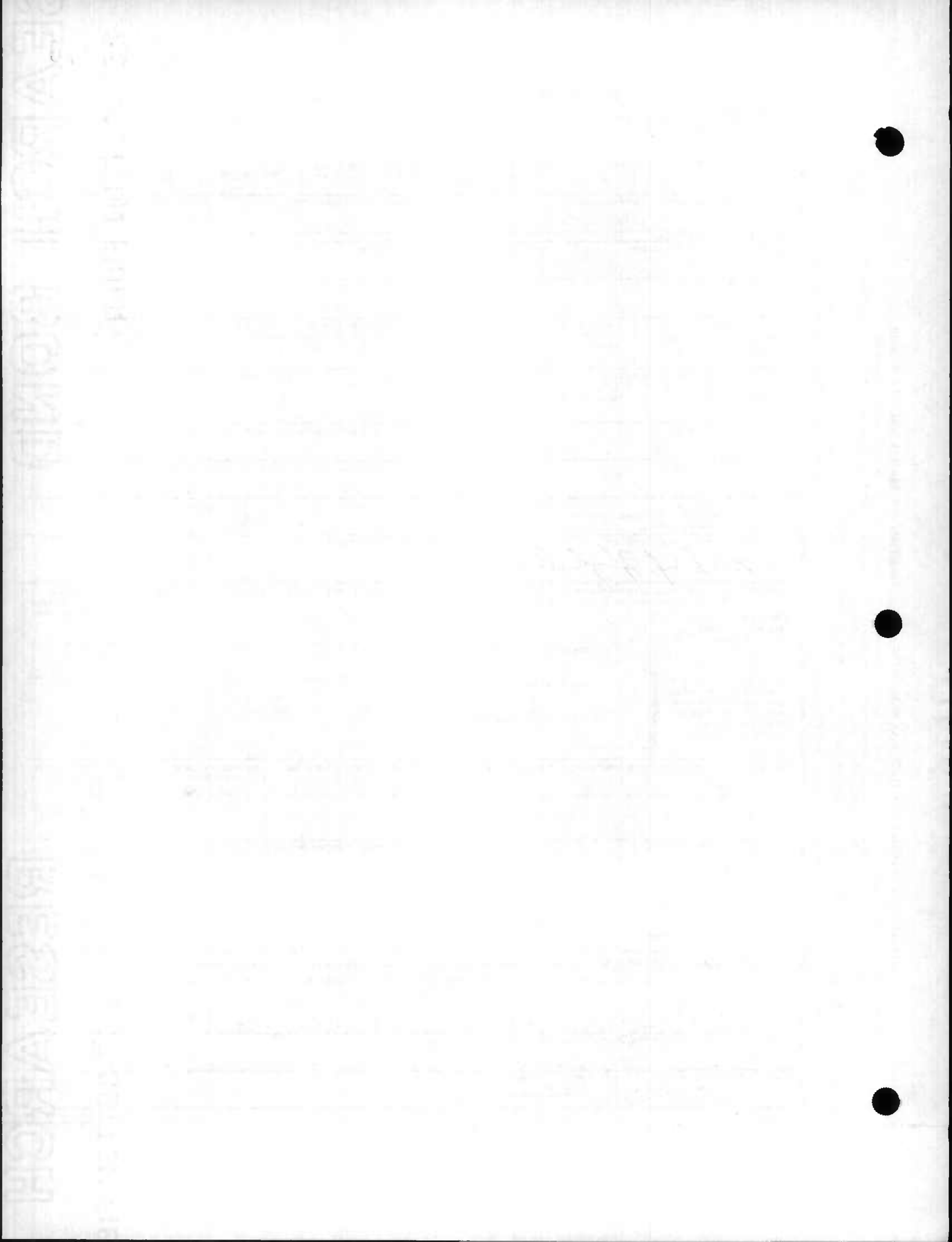
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Elma Hurley</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>28</b> YEAR <b>95</b>		3. TIME OF DEATH <b>9:43 A</b> M	
4. SOCIAL SECURITY NUMBER <b>217-12-4791</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>90</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 31 1904</b>	
8. FACILITY NAME (If not institution, give street and number) <b>Baltimore Regional Burns Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>Baltimore City</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Dorchester</b>		10c. CITY, TOWN OR LOCATION <b>Elliott</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>2350 Elliott Island Rd.</b>			
10f. ZIP CODE <b>21869</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>7</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>retail clerk, crab picker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>clothing store, seafood</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John W. Ewell</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Maggie Hurley</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dennis T. Ewell</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4160 Ocean Gateway, Vienna MD 21869</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Elliott U.M. Churchyard 5/1</b>		20c. LOCATION — City or Town, State <b>Elliott Md.</b>		20d. DATE <b>5/1</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Kenneth R. Thomas Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>Thomas Funeral Home 700 Locust St., Cambridge MD 21613</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>Acidosis</b> DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>ARDS</b> DUE TO (OR AS A CONSEQUENCE OF):							
d. <b>3rd degree Burns</b>							
Approximate Interval Between Onset and Death <b>1wk</b> <b>1wk</b> <b>1wk</b> <b>18 days</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>4/10/95</b>		28b. TIME OF INJURY <b>9:01 A M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>Structure Fire</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>2350 Elliott Rd Vienna MD</b>							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Nancy Clark MD</b>				29c. LICENSE NUMBER <b>AT2438946</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/28/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Baltimore Regional Burn Ctr. Eastern Ave Baltimore, MD</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 03 1995</b>		32. REGISTRAR'S SIGNATURE <b>John A. Hurd</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released on Approval by Medical Examiner

1000



95 14978

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>ELVEE W HORTON</u> ELVEE WASSONHORTON				2. DATE OF DEATH MONTH <u>5</u> DAY <u>6</u> YEAR <u>95</u>		3. TIME OF DEATH <u>11:45 AM</u>	
4. SOCIAL SECURITY NUMBER <u>437-26-7914</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <u>71</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Nov. 21, 1923</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Anne Arundel Medical Center</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Annapolis</u>		9c. COUNTY OF DEATH <u>Anne Arundel</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Anne Arundel</u>		10c. CITY, TOWN OR LOCATION <u>Riva</u>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <u>3060 Tudor Hall Road</u>				10f. ZIP CODE <u>21140</u>		10g. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>X</u>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>5+</u>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Missionary</u>		15b. KIND OF BUSINESS/INDUSTRY <u>Foreign Mission Board Southern Baptist Convention</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Lee Wasson</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Anna Eiland</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Frederick M. Horton Sr.</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3060 Tudor Hall Rd., Riva, Md. 21140</u>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Fort Lincoln Crematory</u>		DATE <u>5/8</u>		20c. LOCATION — City or Town, State <u>Brentwood, Maryland</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>John M. Taylor</u>				22. NAME AND ADDRESS OF FACILITY <u>John M. Taylor Funeral Home, inc. 147 Duke of Gloucester St., Annapolis, Md. 21401</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CIP Arrest</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <u>pleural embolism</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <u></u>							
DUE TO (OR AS A CONSEQUENCE OF):							
d. <u></u>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>9</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <u>N/A</u>		28b. TIME OF INJURY <u>N/A</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <u>N/A</u>				28d. DESCRIBE HOW INJURY OCCURRED <u>N/A</u>			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <u>N/A</u>							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Richard A. B.</u>				29c. LICENSE NUMBER <u>D33069</u>		29d. DATE SIGNED (Month, Day, Year) <u>5/6/95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>RICHARD A. BERASTIN 600 Ridge Ave #14 Annapolis 21401</u>							
31. DATE FILED (Month, Day, Year) <u>MAY 08 1995</u>				32. REGISTRAR'S SIGNATURE <u>Julia A. Rantall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Amerxd- #18 Thompson

95 14979

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Hicks Lucille Lucille Luckham Hicks</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 30 1995</b>		3. TIME OF DEATH <b>8:40 AM</b>	
4. SOCIAL SECURITY NUMBER <b>213-74-0256</b>		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>91 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>Jan 8 1904</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Church Home Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Cockeysville,</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3 Fire Fly Circle Apt. D</b>				10f. ZIP CODE <b>21203</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John Luckham</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Naomi (unknown) Thompson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>W. Laurence Hicks</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3 Fire Fly Circle Apt D Cockeysville, MD 21203</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>St. Anne's Cemetery 5/2/95</b>		20c. LOCATION — City or Town, State <b>Annapolis, Maryland</b>		22. NAME AND ADDRESS OF FACILITY <b>John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>End Stage Congestive Heart Failure</b>					Approximate interval between Onset and Death <b>1yr</b>
		b. <b>Dehydration</b>					<b>2wks</b>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		c. <b>Pneumonia</b>					
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>George E. Wicks III M.D.</b>				29c. LICENSE NUMBER <b>D41365</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 30, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>George E. Wicks III M.D. Church Hospital 100 N. Broadway 21231</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 02 1995</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14980

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ALVIN E. HALL, SR.				2. DATE OF DEATH MONTH DAY YEAR APRIL 26 1995		3. TIME OF DEATH 8:15pm M	
4. SOCIAL SECURITY NUMBER 213-32-4577		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) AUG. 19 1935	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS	
9c. COUNTY OF DEATH ANNE ARUNDEL				10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL	
10c. CITY, TOWN OR LOCATION ANNAPOLIS				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 1201 CARRS ROAD	
10f. ZIP CODE 21401				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1958 - 1960				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 3 1/2 yrs.				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LETTER CARRIER		16b. KIND OF BUSINESS/INDUSTRY U.S. POSTAL SERVICE	
17. FATHER'S NAME (First, Middle, Last) WILLIAM W. HALL				18. MOTHER'S NAME (First, Middle, Maiden Surname) EVELYN CARR			
19a. INFORMANT'S NAME (Type/Print) LaWARREN M. HALL				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1201 CARRS RD. ANNAPOLIS, MD. 21401			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MARYLAND VETERAN CEMETERY 5/2/95		20c. LOCATION — City or Town, State BROWNSVILLE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry D. Reese</i>				22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. <i>pneumonia, bacterial, aspiration</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>cerebrovascular accident</i> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death 3 ms 3 gr							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>multiple myeloma, end stage renal disease, emphysema</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>GAMMILL MD</i>				29c. LICENSE NUMBER D4758		29d. DATE SIGNED (Month, Day, Year) 5-1-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Gregory A. Mitchell 205 Ridgely Ave Annapolis MD 21401</i>							
31. DATE FILED (Month, Day, Year) MAY 01 1995		32. REGISTRAR'S SIGNATURE <i>John A. Buckner</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14981

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GUNZELLA HUNT				2. DATE OF DEATH MONTH DAY YEAR APRIL 18 1995		3. TIME OF DEATH 1:00 PM	
4. SOCIAL SECURITY NUMBER 217-34-7616		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 59 YRS.	7. DATE OF BIRTH (Month, Day, Year) MARCH 24 1936		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) 329 WINDELL AVENUE				9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS		9c. COUNTY OF DEATH ANNE ARUNDEL	
10a. STATE MARYLAND				10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION PASADENA	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 7654 BETH NOELLE COURT				10f. ZIP CODE 21122		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) RETAIL MANAGEMENT		16b. KIND OF BUSINESS/INDUSTRY MONTGOMERY WARDS			
17. FATHER'S NAME (First, Middle, Last) ALEXANDER HARRIS				18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH BESSICK			
19a. INFORMANT'S NAME (Type/Print) NADINE TALLEY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8045 BOSLEY COURT GLEN BURNIE, MD. 21061			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HILL CREST CEMETERY 4/22/95		20c. LOCATION — City or Town, State ANNAPOLIS, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry H. Reese</i>				22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. <i>Metastatic Pancreatic Cancer</i> DUE TO (OR AS A CONSEQUENCE OF): a. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 3 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D20431		29d. DATE SIGNED (Month, Day, Year) 4-25-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1406 B Crain Highway, S. 308 Glen Burnie, MD 21061							
31. DATE FILED (Month, Day, Year) MAY 01 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WESLEY LYLE HILTON</b>				2. DATE OF DEATH MONTH DAY YEAR <b>MAY 02 1995</b>		3. TIME OF DEATH <b>8:10 A M</b>							
4. SOCIAL SECURITY NUMBER <b>214-74-9079</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>37 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>Feb 18, 1958</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>MD. RTE. 301 SOUTH OF MD. RTE. 257</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>NEWBERG</b>		9c. COUNTY OF DEATH <b>CHARLES</b>							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Charles</b>		10c. CITY, TOWN OR LOCATION <b>Newberg</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>9413 Overlook Circle</b>				10f. ZIP CODE <b>20664</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Brick Mason</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Construction</b>									
17. FATHER'S NAME (First, Middle, Last) <b>Bruce L. Hilton</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>H. Corrine Worrell Hilton</b>									
19a. INFORMANT'S NAME (Type/Print) <b>H. Corrine Hilton</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9413 Overlook Circle Newberg, MD 20664</b>									
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Entombment</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Trinity Mausoleum</b>		20c. LOCATION — City or Town, State <b>5-5-95 Waldorf, MD</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>John A. Eberwein</b> <b>MO0173</b>				22. NAME AND ADDRESS OF FACILITY <b>J.H. Eberwein Mortuary</b> <b>4433 White Pls La White Pls., MD 20695</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. Multiple injuries</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>								Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE OF ACCIDENT</b>											
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>Found 5/2/95</b>		28b. TIME OF INJURY <b>unknown</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>unknown</b>					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>roadway</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>W.S. Route 301 in Newberg, Maryland</b>											
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <b>Theodore M. King</b>		29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 03, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>THEODORE M. King</b> <b>111 PENN STREET, BALTIMORE, MARYLAND 21201</b>													
31. DATE FILED (Month, Day, Year) <b>MAY 04 1995</b>		32. REGISTRAR'S SIGNATURE <b>John Andrew Randall</b>											

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



95 14983

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>KATHLEEN LENORA HEATH</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 2 1995</b>		3. TIME OF DEATH <b>5:04 PM</b>	
4. SOCIAL SECURITY NUMBER <b>188-42-6915</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>96</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 10 1898</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Dorchester General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cambridge</b>		9c. COUNTY OF DEATH <b>Dorchester</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Dorchester</b>		10c. CITY, TOWN OR LOCATION <b>Cambridge</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>520 Glenburn Ave.</b>				10f. ZIP CODE <b>21613</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 10</b>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Thomas H. LeCompte</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lena Adkins</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Lorraine A. Urbine</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2515 Bryan Drive, Wilmington DE 19808</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dorchester Memorial Park 5/4</b>		20c. LOCATION — City or Town, State <b>Cambridge Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kenneth R. Thomas Jr.</i>				22. NAME AND ADDRESS OF FACILITY <b>Thomas Funeral Home 700 Locust St. Cambridge MD 21613</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Aspiration Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>5 days</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Organic Brain Syndrome</b> <b>Concertive Heart Failure</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edmund J. MacLaughlin MD</i>				29c. LICENSE NUMBER <b>D-28209</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 2, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Edmund J. MacLaughlin 4 Aurora St. Cambridge, Md 21613</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 04 1995</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14984

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>TRUITT Martin JONES</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>27</b> YEAR <b>95</b>		3. TIME OF DEATH <b>12:00 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>214-28-3004</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>63</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-16-31</b>	
8. FACILITY NAME (If not institution, give street and number) <b>Harrison House Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SNOW HILL</b>		9c. COUNTY OF DEATH <b>Worcester</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Worcester</b>		10c. CITY, TOWN OR LOCATION <b>SNOW HILL</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>442 COVERINGTON ST</b>				10f. ZIP CODE <b>21863</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4+</b> College (1-4 or 5+) <b>4+</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housekeeper</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Nursing Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>James A. James</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Evelyn TRUITT</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Earnestine Bailey</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Post Office Box 301 SNOW HILL, Md.</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT Wesley 5/1/96 SNOW HILL, Md.</b>		20c. LOCATION — City or Town, State		Approximate Interval Between Onset and Death <b>FEW WEEKS</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Keith E. Wharton</b>				22. NAME AND ADDRESS OF FACILITY <b>WHARTON FUNERAL HOME 2271 Wharton Rd. Accomac, VA</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>METASTATIC LUNG CARCINOMA</b> DUE TO (OR AS A CONSEQUENCE OF):							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				29. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dorothy C. Holzworth, M.D.</b>				29c. LICENSE NUMBER <b>D06241</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-27-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DOROTHY C. HOLZWORTH 703 SNOW ST. SNOW HILL, MD. 21863</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 01 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Anderson-Randall</b>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

2

95 14985

AMENDED #2 4/26/95 ELM P.G.C.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Bertha C. Janof				2. DATE OF DEATH MONTH DAY YEAR April 20, 1995		3. TIME OF DEATH 17:48 M	
4. SOCIAL SECURITY NUMBER 579-16-6134		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3/16/18	
8a. FACILITY NAME (If not institution, give street and number) Calvert Memorial Hospital				8b. CITY, TOWN OR LOCATION OF DEATH Prince Frederick		8c. BIRTHPLACE (State or Foreign Country) Washington, D.C.	
9. COUNTY OF DEATH Calvert							
10a. STATE Maryland		10b. COUNTY Calvert		10c. CITY, TOWN OR LOCATION Dunkirk		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1428 Knight Ave.				10f. ZIP CODE 20754		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 12th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY at home			
17. FATHER'S NAME (First, Middle, Last) William E. Johnson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emily Berry			
19a. INFORMANT'S NAME (Type/Print) William M. Janof				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as item 10			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery 4/24/95		20c. LOCATION — City or Town, State Suitland, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George P. Kalas</i>				22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ventricular Fibrillation DUE TO (OR AS A CONSEQUENCE OF): b. Severe Ischemic Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Type II Diabetes Mellitus; Atrial Fibrillation Peripheral Vascular Disease							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Lowenthal</i>				29c. LICENSE NUMBER 033123		29d. DATE SIGNED (Month, Day, Year) 4-20-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Lowenthal Prince Frederick, MD. 20678							
31. DATE FILED (Month, Day, Year) APR 24 1995		32. REGISTRAR'S SIGNATURE <i>Julia Driscoll Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

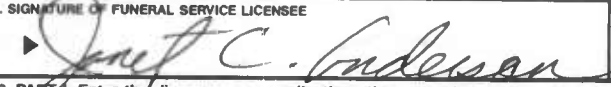
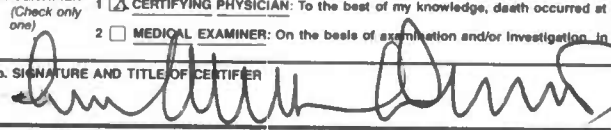
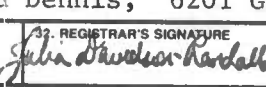




95 14986

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RAYMOND JOYNER</b>				2. DATE OF DEATH MONTH <b>4</b> DAY <b>17</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>4:30</b> M	
4. SOCIAL SECURITY NUMBER <b>577-68-1943</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>46</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10/29/48</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Hyattsville Health Care Center</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Hyattsville Md</b>		8c. BIRTHPLACE (State or Foreign Country) <b>Washington D.C.</b>	
9. RESIDENCE OF DECEDENT				9c. COUNTRY OF DEATH <b>P.G.</b>			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Hyattsville</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6500 Riggs Road</b>				10f. ZIP CODE <b>20783</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (6-12)</b> <b>12th grade</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Cook</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Italian Restaurant</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Frank Joyner</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Hazel Harley</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Elsie Slaughter (Sister)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6705 Vermont Court Hyattsville, Maryland 20785</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of place, City or Town, State, Zip Code) <b>National Harmony Memorial Park</b>		20c. DATE <b>4/25/95</b>		20d. LOCATION — City or Town, State <b>Landover, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Rollins Funeral Home, Inc.</b> <b>4339 Hunt Place, N.E. Washington, D.C. 20019</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ACQUIRED IMMUNE DEFICIENCY SYNDROME</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death <b>UNKNOWN</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ANEMIA, LEUKOPENIA, WASTING SYNDROME, DEMENTIA</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO						24c. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D01499</b>		29d. DATE SIGNED (Month, Day, Year) <b>April 20, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Lewis Hilliard Dennis, 6201 Greenbelt Road #U-1 College Park, MD 20740</b>							
31. DATE FILED (Month, Day, Year) <b>APR 27 1995</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


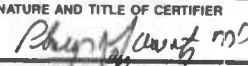
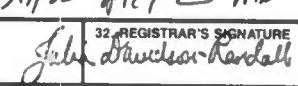
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14987

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Lindsey Johnson</b>				2. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>31</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>730 A</b> M	
4. SOCIAL SECURITY NUMBER <b>579-18-5734</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-7-1916</b>	
8. FACILITY NAME (If not institution, give street and number) <b>Shady Grove Hospital</b>				9. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>		10. COUNTY OF DEATH <b>MD MONT.</b>	
11. RESIDENCE OF DECEDENT 10a. STATE <b>MD</b> 10b. COUNTY <b>Montgomery</b> 10c. CITY, TOWN OR LOCATION <b>Rockville</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>Collingwood Nursing Home 299 HURLEY AVE.</b>	
10f. ZIP CODE <b>20850</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (13-16) <b>No</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Waiter</b>	
16b. KIND OF BUSINESS/INDUSTRY <b>Restaurant</b>		17. FATHER'S NAME (First, Middle, Last) <b>Wesley Johnson</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth</b>		19a. INFORMANT'S NAME (Type/Print) <b>Linda Forsyth</b>	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2613 Molton Way, Baltimore, MD 21244</b>		20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HOWARD UNIV. MED. SCHOOL 4/4/95 WASH., D.C.</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>AAMAN Funeral Service POB 9495 Washington DC 20016</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Aspiration Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Gastrointestinal Bleeding</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Gastrointestinal Failure</b> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Acute renal Failure</b> <b>Alzheimer's disease</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>024398</b>		29d. DATE SIGNED (Month, Day, Year) <b>MARCH 31, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Philip J. J. Smith MD 15225 SHADY GROVE ROAD Suite 302 Rockville, MD 20850</b>							
31. DATE FILED (Month, Day, Year) <b>APR 26 1995</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14988

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Dola Frances James</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 2, 1995</b>		3. TIME OF DEATH <b>7:35 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>233-30-6654</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>92</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10-27-1903</b>	
8. BIRTHPLACE (State or Foreign Country) <b>N. Virginia</b>				9. FACILITY NAME (If not institution, give street and number) <b>Anne Arundel Medical Center</b>			
10. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>				11. COUNTY OF DEATH <b>Anne Arundel</b>			
12a. STATE <b>Maryland</b>		12b. COUNTY <b>Anne Arundel</b>		12c. CITY, TOWN OR LOCATION <b>Annapolis</b>		12d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
13a. STREET AND NUMBER <b>570 Bellerive Road</b>				13b. ZIP CODE <b>21401</b>		13c. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		15. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		16. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		17. RACE — American Indian, Black, White, etc. Specify: <b>Caucasian</b>	
18. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>12+</b> College (1-4 or 5+) <b></b>				19. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		20. KIND OF BUSINESS/INDUSTRY <b>Home</b>	
21. FATHER'S NAME (First, Middle, Last) <b>Daniel Teets</b>				22. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Cora Riffle</b>			
23. INFORMANT'S NAME (Type/Print) <b>Mr. Homer James</b>				24. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>203 Bertram Circle Glen Burnie, MD 21060</b>			
25. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		26. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery 5-5-95</b>		27. DATE <b>Brooklyn, MD</b>		28. LOCATION — City or Town, State	
29. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				30. NAME AND ADDRESS OF FACILITY <b>Barranco &amp; Sons Funeral Home 21146 495 Ritchie Hwy Severna Park, MD</b>			
31. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>cardiac arrest</b> Approximate Interval Between Onset and Death: <b>4 minutes</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>cerebrovascular disease</b> one year							
32. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b></b>							
33. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				34. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
35. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		36. DATE OF INJURY (Month, Day, Year) <b></b>		37. TIME OF INJURY <b>M</b>		38. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
39. DESCRIBE HOW INJURY OCCURRED <b></b>				40. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b></b>			
41. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
42. SIGNATURE AND TITLE OF CERTIFIER <i>Stuart E. Selonick</i>				43. LICENSE NUMBER <b>019838</b>		44. DATE SIGNED (Month, Day, Year) <b>5/2/95</b>	
45. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Stuart E. Selonick, M.D.</b>							
46. DATE FILED (Month, Day, Year) <b>MAY 09 1995</b>				47. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10/10/10

95 14989

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ELLA M. JONES ELLA MARIE JONES</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>2</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>132 P M</b>	
4. SOCIAL SECURITY NUMBER <b>217-30-4536</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>60</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>DEC. 23-34</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>North Arundel Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Glen Burnie</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>ANNE ARUNDEL</b>		10c. CITY, TOWN OR LOCATION <b>RURAL-CROWNSVILLE</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1073 BALTIMORE HILL ROAD</b>				10f. ZIP CODE <b>21032</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Widowed 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Divorced 4 <input type="checkbox"/> Other		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES: <b>XXX</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>AFRO AMERICAN</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>??</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CLERK TYPIST</b>		16b. KIND OF BUSINESS/INDUSTRY <b>+++++</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOHN JONES SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARGARET LOUISE RIDGELEY</b>			
19a. INFORMANT'S NAME (Type/Print) <b>SAME AS # 18</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS # 10 E</b>			
20a. MANNER OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>NRADON RIDGEMAY 5-95</b>		DATE <b>RT. # 1 MARYLAND</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>CHARLES E. HICKS</b>				22. NAME AND ADDRESS OF FACILITY <b>ANNAPOLIS, MD. 21401 HOUSE OF HICKS 1922 FOREST DRIVE</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Metastatic Breast Cancer</b>					
		b. <b>DIABETES Mellitus</b>					
		c. <b>HYPERTENSION</b>					
		d.					
Approximate Interval Between Onset and Death <b>1 year</b> <b>5 years</b> <b>5 years</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ACUTE TRANSVERSE MYELITIS Ty SPINAL CORD. OLD THALAMIC INFARCTION</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>David H. Schmiedeler MD</b>				29c. LICENSE NUMBER <b>D28221</b>		29d. DATE SIGNED (Month, Day, Year) <b>May 2, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DAVID H. SCHMIEDER, MD 301 HOSPITAL DRIVE, GLEN BURNIE MARYLAND</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 08 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





95 14990

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>NORA QUEEN KRIZMENCIC</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>30</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>12:25</b> M	
4. SOCIAL SECURITY NUMBER <b>236 82 1988</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH MONTH <b>MAY</b> DAY <b>1</b> YEAR <b>1911</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>W. VA.</b>		10b. COUNTY <b>MINERAL</b>		10c. CITY, TOWN OR LOCATION <b>SHORT GAP</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>RFD# 2 KEYSER</b>				10f. ZIP CODE <b>26726</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>XXX</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSE KEEPER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOUSE KEEPER</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ELLIS LEE SULLIVAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>QUEEN ESTHER BARNES</b>			
19a. INFORMANT'S NAME (Type/Print) <b>NORA L. BUSER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>944 BEDFORD STREET CUMBERLAND MARYLAND 21502</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>SS PETER &amp; PAUL CEMETERY MAY 3, 1995 CUMBERLAND MARYLAND</b>		20c. LOCATION — City or Town, State <b>CUMBERLAND MARYLAND</b>		20d. DATE <b>MAY 3, 1995</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY <b>MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>MYOCARDIAL INFARCTION - ACUTE</b>					Approximate Interval Between Onset and Death <b>10 minutes</b>
		b. <b>CORONARY ARTERY DISEASE</b>					<b>12 months</b>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. <b></b>					
		d. <b></b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES</b> <b>RECTAL CARCINOMA</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D33417 (MD)</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 1, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JAMES R. MOEN, MD. 1068 NATIONAL HWY-REAR LAVALE, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 01 1995</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14991

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elaine Josephine Kerns				2. DATE OF DEATH MONTH DAY YEAR April 30, 1995		3. TIME OF DEATH 12:45AM M	
4. SOCIAL SECURITY NUMBER 218-38-0635		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 27, 1941	
8. BIRTHPLACE (State or Foreign Country) Ohio				9a. FACILITY NAME (If not institution, give street and number) 9133 East Stayman Drive		9b. CITY, TOWN OR LOCATION OF DEATH Ellicott City	
9c. COUNTY OF DEATH Howard County				10a. STATE Maryland		10b. COUNTY Howard County	
10c. CITY, TOWN OR LOCATION Ellicott City				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 9133 East Stayman Drive	
10f. ZIP CODE 21042				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+) 2+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Medical Technition		16b. KIND OF BUSINESS/INDUSTRY Hospital	
17. FATHER'S NAME (First, Middle, Last) Steve ----- Anta				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anita ----- Fuente			
19a. INFORMANT'S NAME (Type/Print) David G. Kerns				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9133 East Stayman Drive, Ellicott City			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Peter's Cemetery 5/4		20c. LOCATION — City or Town, State Westernport, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Franklin H. Guster</i>				22. NAME AND ADDRESS OF FACILITY Boal Funeral Home 111 Church St. Westernport, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. HIGH GRADE LYMPHOMA DUE TO (OR AS A CONSEQUENCE OF): b. HYPER CALCEMIA DUE TO (OR AS A CONSEQUENCE OF): c. Approximate Interval Between Onset and Death 14 Months 14 Months							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Vinicio Hernandez, MD</i> HOUSE OFFICER				29c. LICENSE NUMBER UJN 07345		29d. DATE SIGNED (Month, Day, Year) 4/30/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VINICIO HERNANDEZ 22 S. GREENE ST., BALTIMORE, MD 21204							
31. DATE FILED (Month, Day, Year) MAY 01 1995				32. REGISTRAR'S SIGNATURE <i>Elaine Kerns</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20



95 14992

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Ruth M. Klingler</b>				2. DATE OF DEATH MONTH DAY YEAR <b>04-28-1995</b>		3. TIME OF DEATH <b>11:20 PM</b>	
4. SOCIAL SECURITY NUMBER <b>368 18 0491</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>92</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JAN 28 1903</b>	
8. BIRTHPLACE (State or Foreign Country) <b>OHIO</b>				9a. FACILITY NAME (If not institution, give street and number) <b>CUMBERLAND NURSING HOME</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>	
9c. COUNTY OF DEATH <b>ALLEGANY</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ALLEGANY</b>	
10c. CITY, TOWN OR LOCATION <b>LAVALLE</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>10 GRANT DRIVE</b>	
10f. ZIP CODE <b>21502</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>10</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>KLINGLER HEATING &amp; AIR COND. CO. HEATING/AIR CONDITIONING</b>				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>JAMES J. ACKON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MALINDA SHAW</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ROBERT G. KLINGLER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1015 MYRTLE STREET CUMBERLAND MARYLAND 21502</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HILLCREST CEMETERY MAY 1, 1995</b>			
20c. LOCATION — City or Town, State <b>CUMBERLAND MARYLAND</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>			
22. NAME AND ADDRESS OF FACILITY <b>MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Coronary heart failure</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>AF</b> <b>CAD</b>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Severe hypothyroidism</b>			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>MAY 1 1995</b>			
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Peter H. Schley</i>				29c. LICENSE NUMBER <b>10 4981</b>			
29d. DATE SIGNED (Month, Day, Year) <b>April 28, 1995</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PETER H. SCHLEY 302 Schley St Cumberland, Md.</b>			
31. DATE FILED (Month, Day, Year) <b>MAY 01 1995</b>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

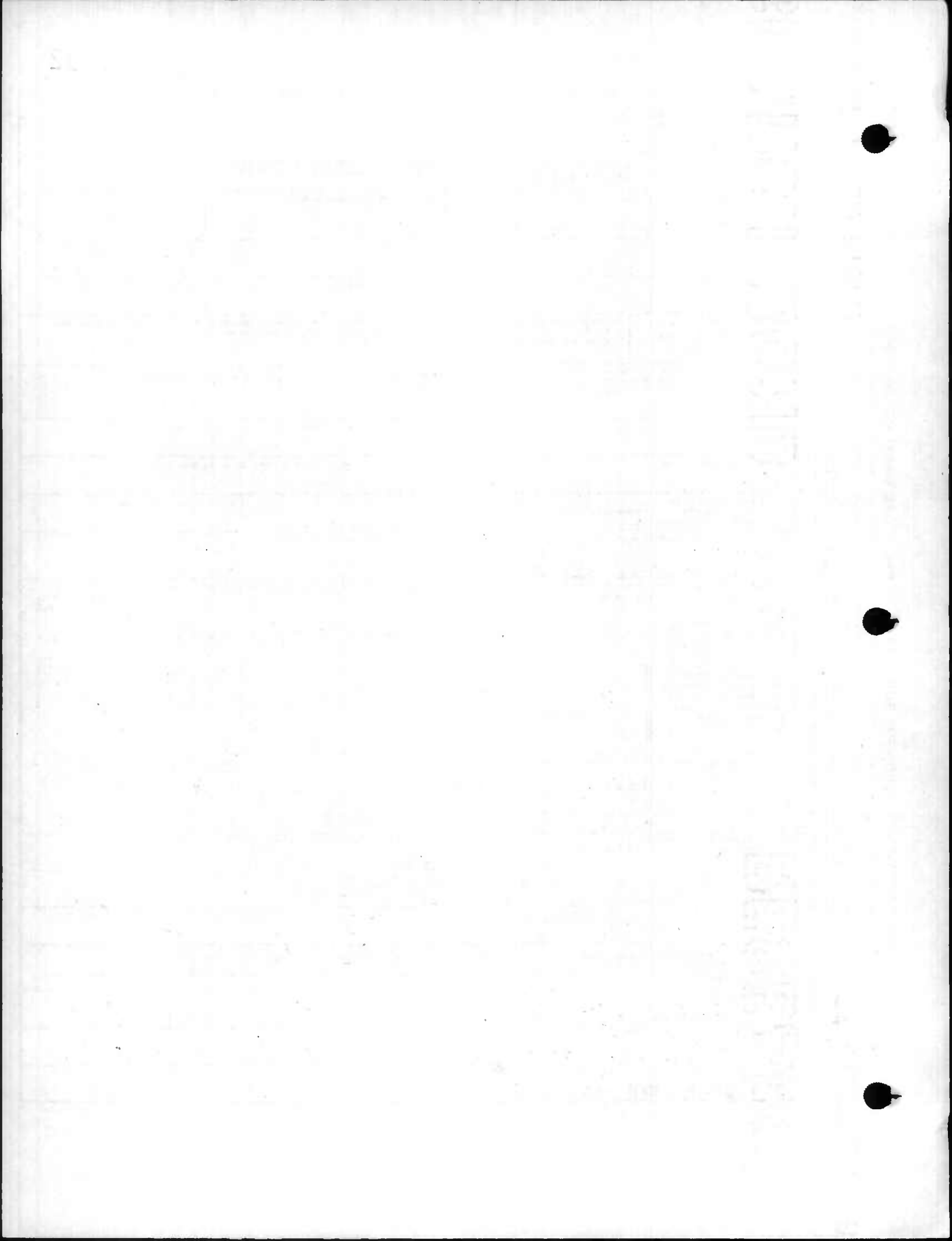
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 14993

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Samuel James Kimbles Sr.				2. DATE OF DEATH MONTH DAY YEAR May 2, 1995		3. TIME OF DEATH A 11:07 M	
4. SOCIAL SECURITY NUMBER 220-01-6313		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) June 22, 1915	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. FACILITY NAME (If not institution, give street and number) The Kent and Queen Anne's Hospital Inc.		10. CITY, TOWN OR LOCATION OF DEATH Chestertown	
11. COUNTY OF DEATH Kent				12. RESIDENCE OF DECEDENT			
10a. STATE Maryland		10b. COUNTY Queen Anne's		10c. CITY, TOWN OR LOCATION Price		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 114 Massey Avenue				10f. ZIP CODE 21656		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 8+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter/Contractor		16b. KIND OF BUSINESS/INDUSTRY Self-employed			
17. FATHER'S NAME (First, Middle, Last) Samuel Coston Kimbles				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cora Green			
19a. INFORMANT'S NAME (Type/Print) Mary Elizabeth Kimbles				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 114 Massey Ave., Price, Md. 21656			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Church Hill Cemetery May 5, 1995		20c. LOCATION — City or Town, State Church Hill, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Tom Helfenbein</i>				22. NAME AND ADDRESS OF FACILITY Tom Helfenbein Funeral Homes, P.A. 555 Main St., Church Hill, Md.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>DIFFUSE INTRA ABDOMINAL LIPOSARCOMA</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>hemorrhagic GASTRITIS</u> <u>PROSTATE CANCER</u>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY N/A M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				29. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Patrick J. Sarnahan</i>				29c. LICENSE NUMBER D86054		29d. DATE SIGNED (Month, Day, Year) 5/3/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PATRICK J. SARNAHAN 120 SPEER ROAD CHESTERTOWN MD 21620							
31. DATE FILED (Month, Day, Year) MAY 04 1995				32. REGISTRAR'S SIGNATURE <i>John D. Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 14994

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GOLDIE ANN LASHLEY</b>				2. DATE OF DEATH MONTH <b>APRIL</b> DAY <b>30</b> YEAR <b>1995</b>		3. TIME OF DEATH <b>07:40 A</b> M	
4. SOCIAL SECURITY NUMBER <b>218 74 9786</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>94</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 8 1901</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Mt. Savage</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>Route 1 Box 109</b>				10f. ZIP CODE <b>21545</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Domestic</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Howard Shaffer</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Carrie Porter</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Roberta Bonnici</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>318 Fairi Chase Chesapeake, Virginia 23320</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sunset Memorial Park May 3, 95</b>		20c. LOCATION — City or Town, State <b>Cumberland, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John R. Durst</i>				22. NAME AND ADDRESS OF FACILITY <b>Durst Funeral Home 57 Frost Avenue Frostburg, Md. 21532</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory failure acute 2 hours</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Pneumonia bilateral 2 days</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Congestive heart failure 2 yrs</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypothyroidism, some dementia</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>S. Kim</i>				29c. LICENSE NUMBER <b>015463</b>		29d. DATE SIGNED (Month, Day, Year) <b>APRIL 30, 1995</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <b>Dr. S. Kim 90 Main Street Westernport, Maryland 21562</b>							
31. DATE OF FILING (Month, Day, Year) <b>MAY 03 1995</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) (A.K.A. Jessie Leap) LAURA LEAP				2. DATE OF DEATH MONTH DAY YEAR APRIL 19, 1995		3. TIME OF DEATH 4:50 A.M.	
4. SOCIAL SECURITY NUMBER 578-01-7742		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH MONTH DAY YEAR Oct. 6, 1912	
8a. FACILITY NAME (If not institution, give street and number) Prince George's Hospital Center				8b. CITY, TOWN OR LOCATION OF DEATH Cheverly		8c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Hyattsville		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 7729 Frederick Road				10f. ZIP CODE 20784		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk		16b. KIND OF BUSINESS/INDUSTRY International Brotherhood of Electrical Workers			
17. FATHER'S NAME (First, Middle, Last) Elmer G. Hobbs				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Reeder			
19a. INFORMANT'S NAME (Type/Print) Irma Ripple				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7408 Upshur Street, Landover Hills, MD 20784			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 04/21/95		20c. LOCATION — City or Town, State Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Constance Gasch</i>				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cerebrovascular Hemorrhage</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		29a. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i>				29c. LICENSE NUMBER D21230		29d. DATE SIGNED (Month, Day, Year) April 19, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augusto P. Rodriguez MD, 5009 Rayburn Ct. Sp. - Md 20748</i>							
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14996

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY K. LEGRAND</b>				2. DATE OF DEATH MONTH DAY YEAR <b>4/20/95</b>		3. TIME OF DEATH <b>3/30 A M</b>	
4. SOCIAL SECURITY NUMBER <b>579-54-2129</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>52</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6/9/42</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>9710 Kisonko Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Ft Washington</b>		9c. COUNTY OF DEATH <b>PG</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md</b>		10b. COUNTY <b>PG</b>		10c. CITY, TOWN OR LOCATION <b>Ft Washington</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>9710 Kiskonko Road</b>				10f. ZIP CODE <b>20744</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Postal Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>US Postal Service</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Julius Kinard</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Pearl Jackson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>James LeGrand</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10a,b,c,d,e,&amp;f</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Ft Lincoln Cemetery 4/25/95</b>		20c. LOCATION — City or Town, State <b>Brentwood, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Juan Smith</b>				22. NAME AND ADDRESS OF FACILITY <b>John T. Rhines Co., Inc. 3030 12th St NE, DC 20017</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Cardio pulmonary Arrest</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Metastatic Adenocarcinoma</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Liver Failure</b> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Veronica Jenkins</b>				29c. LICENSE NUMBER <b>D39973</b>		29d. DATE SIGNED (Month, Day, Year) <b>4-20-95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Veronica Jenkins</b>							
31. DATE FILED (Month, Day, Year) <b>APR 25 1995</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14997

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Clystie Leach</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 23, 1995</b>		3. TIME OF DEATH <b>7:30 P. M.</b>	
4. SOCIAL SECURITY NUMBER <b>216-22-2671</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 12, 1926</b>	
9a. FACILITY NAME (If not Institution, give street and number) <b>311 Bogota Drive</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Fort Washington</b>		9c. COUNTY OF DEATH <b>Prince George's</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Fort Washington</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>311 Bogota Drive</b>			
10f. ZIP CODE <b>20744</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Secondary-10th</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Assembler</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Naval Base Indianhead</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Thomas Henson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mable Henson nee Savoy</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Yvonne Ford</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>77489 1603 Stone Lake Dr., Missouri City, Texas</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		DATE <b>4/95</b>		20c. LOCATION — City or Town, State <b>Alexandria, Virginia</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Charles C. Shiggett</b>				22. NAME AND ADDRESS OF FACILITY <b>House of Diggs Mortuary 4906 Iverson Pl., Temple Hills, MD 20748</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Carcinoma of The Breast</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						Approximate Interval Between Onset and Death <b>not</b>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>D19931</b>		29d. DATE SIGNED (Month, Day, Year) <b>4/24/95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Frank M. Ryan M.D. 6188 Oxon Hill Rd #601 Oxon Hill MD 20745</b>							
31. DATE FILED (Month, Day, Year) <b>APR 25 1995</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3





95 14998

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES ANDREW LEWIS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>April 30, 1995</b>		3. TIME OF DEATH <b>11:30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>579-70-1613</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>43</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 20, 1952</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>126 Blue Lockspur Drive</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Hollywood</b>		9c. COUNTY OF DEATH <b>St. Mary's</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>St. Mary's</b>		10c. CITY, TOWN OR LOCATION <b>Hollywood</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>126 Blue Lockspur Drive</b>				10f. ZIP CODE <b>20636</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Foreman</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Foreman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Construction</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Jessie James Lewis</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Barbara Fenton</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Theresa Ann Lewis</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>126 Blue Lockspur Drive, Hollywood, MD 20636</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Charles Memorial Gardens</b>		20c. LOCATION — City or Town, State <b>5-5 Leonardtown, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Mark G. Brohawn M00053</b>				22. NAME AND ADDRESS OF FACILITY <b>Huntt Funeral Home P. O. Box 156, Waldorf, MD 20604-0156</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MALIGNANT MELANOMA</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
<b>METASTATIC DISEASE</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Theresa Ann Lewis</b>				29c. LICENSE NUMBER <b>D34539</b>		29d. DATE SIGNED (Month, Day, Year) <b>5. 1. 95</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Kharid M. Humani MD, 662 Maryland ST # 101 LEONARDTOWN MD 20650</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 04 1995</b>				32. REGISTRAR'S SIGNATURE <b>John A. Woodson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 14999

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jean Meister				2. DATE OF DEATH MONTH DAY YEAR May 2 1995				3. TIME OF DEATH 8:00PM M					
4. SOCIAL SECURITY NUMBER 218-16-4649		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) MARCH 5 1923		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) 919 Harding Street						9b. CITY, TOWN OR LOCATION OF DEATH Cumberland				9c. COUNTY OF DEATH Allegany			
RESIDENCE OF DECEDENT													
10a. STATE MARYLAND				10b. COUNTY ALLEGANY				10c. CITY, TOWN OR LOCATION CUMBERLAND				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 919 HARDING AVE						10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) KELLY SPRINGFIELD TIRE CO.				16b. KIND OF BUSINESS/INDUSTRY MANUF. TIRES					
17. FATHER'S NAME (First, Middle, Last) LAWRENCE E. MEISTER						18. MOTHER'S NAME (First, Middle, Maiden Surname) ELSIE ZEMBOWER							
19a. INFORMANT'S NAME (Type/Print) ROBERT H. MEISTER						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 919 HARDING AVE. CUMBERLAND MARYLAND 21502							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or crematorium or other place) SUNSET CEMETERY MAY 5 1995				DATE		20c. LOCATION — City or Town, State CUMBERLAND MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinomatous DUE TO (OR AS A CONSEQUENCE OF):												3 months	
b. Carcinoma of Breast DUE TO (OR AS A CONSEQUENCE OF):												2 years	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER D 16041				29d. DATE SIGNED (Month, Day, Year) May 2, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. T. Williams, Memorial Hospital Medical Bldg., Cumberland, MD 21502													
31. DATE FILED (Month, Day, Year) MAY 04 1995				32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 15000

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>THELMA AGNES MINKE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>APRIL 26, 1995</b>		3. TIME OF DEATH <b>10:15 A M</b>	
4. SOCIAL SECURITY NUMBER <b>214-28-6742</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>91</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jun 24, 1903</b>	
8. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				9. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>		10. COUNTY OF DEATH <b>ALLEGANY</b>	
11. STATE <b>MD</b>		12. COUNTY <b>Allegany</b>		13. CITY, TOWN OR LOCATION <b>Cumberland</b>		14. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
15. STREET AND NUMBER <b>255 Williams Street</b>				16. ZIP CODE <b>21502</b>		17. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
18. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		19. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		21. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
22. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		24. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
25. FATHER'S NAME (First, Middle, Last) <b>Walter Moore</b>				26. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth Simpson</b>			
27. INFORMANT'S NAME (Type/Print) <b>Betty Underdonk</b>				28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1367 Cottonwood Circle Ft. Lauderdale, FL 33326</b>			
29. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sunset Memorial Park</b>		31. DATE <b>05/01</b>		32. LOCATION — City or Town, State <b>Cumberland, MD</b>	
33. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Gary F. Scarpelli</b>				34. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>			
35. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>congestive heart failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>coronary artery disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>old myocardial infarct</b> DUE TO (OR AS A CONSEQUENCE OF): SEQUENTIALLY LIST CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Urinary tract infection</b> <b>renal failure</b>							
36. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Urinary tract infection</b> <b>renal failure</b>							
37. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		38. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
39. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
40. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		41. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
42. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		43. DATE OF INJURY (Month, Day, Year)		44. TIME OF INJURY <b>M</b>		45. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
46. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				47. DESCRIBE HOW INJURY OCCURRED			
48. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
49. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
50. SIGNATURE AND TITLE OF CERTIFIER <b>R. Espina, MD</b>				51. LICENSE NUMBER <b>DD03459</b>		52. DATE SIGNED (Month, Day, Year) <b>APRIL 27, 1995</b>	
53. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>R. ESPINA, MD 902 SETON DR., CUMBERLAND, MD</b>							
54. DATE FILED (Month, Day, Year) <b>MAY 01 1995</b>				55. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

